Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting

Hospital Boardroom
Chair: Prof. Chris Edwards
Date: 8 May 2008
Time: 4:30pm

Agenda

1. GENERAL BUSINESS	**4.30pm**
1.1 Apologies for Absence	**CE**
1.2 Declaration of Interests	**CE**
1.3 Minutes of Previous Meeting held on 14 February 2008 (attached)	**CE**
1.4 Matters Arising (attached)	**CE**
1.5 Chairman's Report (oral)	**CE**
1.6 Chief Executive's Report (attached)	**HL**
2. ITEMS FOR DISCUSSION/DECISION/APPROVAL	**4:45pm**
2.1 Financial and Corporate Plan (attached)	**LB**
2.2 Staff Constituencies (attached)	**CE**
2.3 Membership: Recruitment, Engagement and Sub Committee Highlights (attached)	**CE**
2.4 Membership Week Report (oral)	**CE/JC**
2.5 Open Day Update (oral)	**HL**
2.6 Members' Council Performance Evaluation (attached)	**CE**
2.7 Members' Council Funding Criteria (attached)	**CE**
3. ITEMS FOR INFORMATION	**5:30**
3.1 Finance Report – Month 12 (attached)	**LB**
3.2 Performance Report – Month 12 (attached)	**LB**
4. ANY OTHER BUSINESS	
5. DATE OF THE NEXT MEETING	
24 July 2008	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting Minutes, 14 February 2008

Present:

[Quorum: 12 Council Members with a minimum of 4 public/patient, 1 Staff and 2 appointed]

Council Members:
Chris Edwards (CE), Chairman
June Bennett (JB), Patient
Walter Balmford (WB), Patient
June Smith (JS), Patient
Sue B Smith (SBS), Patient
Sue M Smith
Mary Symons (MS), Wandsworth Area 1
Martin Bradford (MB), Hammersmith and Fulham Area 1
Martin Lewis, Westminster Area 2
Brian Gazzard (BG), Staff – Medical & Dental
Duncan Macrae, Appointed - Royal Brompton & Harefield NHS Trust
Christine Blewett (CBT), Public – Hammersmith & Fulham 2
Mervyn Maze (MM), Imperial College
Frances Taylor (FT), Appointed - Royal Borough of Kensington & Chelsea
Valerie Arends (VA), Public – Kensington and Chelsea
Lionel Foulkes (LF), Public – Wandsworth 2
Maria-Elena Arana (MA), Patient
Vivian Wood (VW), Hammersmith and Fulham PCT
Peter Molyneux (PM), Appointed, Kensington & Chelsea PCT
Alison Delamare (AD), Staff – Contracted
Cathy James (CJ), Staff – A&C
Martin Rowell (MR), Patient
Ann-Mills Duggan (AMD), Public – Westminster Area 1
Nathan Billing (NB), Staff-Allied Health Professionals
Chris Birch (CB), Patient

In Attendance:
Heather Lawrence (HL), Chief Executive
Cathy Mooney (CM), Director of Governance and Corporate Affairs
Julie Cooper (JC), Foundation Trust Secretary
Colin Glass (CG), NED
Charles Wilson (CW), NED
Andrew MacCallum, Director of Nursing
Karin Norman (KN), NED
Maxine Foster (MFo), Director of Human Resources
Charles Wilson (CW), Non-Executive Director
Lorraine Bewes, Director of Finance
Hannah Coffey, Director of Operations

1. GENERAL BUSINESS

1.1 Apologies for Absence

Apologies for absence were received from:
Nicky Browne (NBr), Royal Marsden NHS Foundation Trust
Catherine Longworth (CL), Westminster PCT
Jane King (JK), Patient
Hugo Fitzgerald (HF), Patient
Prof Salman Rawaf (SR), Appointed, Wandsworth PCT
Sandra Jowett (SJ), Appointed – Thames Valley University
Raymond Levy (RL), Kensington and Chelsea Area 1

1.2 Declaration of Interests

There were no declarations of interest and the register of interests was circulated as a separate item for all new members.

1.3 Minutes of the Previous Meeting Held 20 September 2007

The minutes were approved with the following amendment:

P.3 First and second references to 'CB' are Chris Birch, but the third is Christine Blewett. Christine Blewett will now be referred to as CBT.

1.4 Matters arising

Business Planning (2.1/Nov/07)
The draft corporate business plan was discussed under agenda item 2.1.

Membership Report (2.4/Nov/07)
The staff opt option was discussed under agenda item 2.2.

Membership Engagement (2.6/Nov/07)
Communication with the membership was discussed under agenda item 2.4.
JC reported that all Council Members are now on the Trust website and can be contacted by e-mail via the Trust Secretary.

National Governor's Forum (2.7/Nov/07)
As above, all Council Members are now on the Trust website and can be contacted by e-mail via the Trust Secretary.

Healthcare Commission Standards for Better Heath (2.3/Nov/07)
This item was discussed under agenda item 2.3.

1.5 Chairman's Report

The Chairman welcomed the new Council Members. He noted that we have a newly designed Foundation Trust website and asked that all new members send their picture, profile and consent to Matt Akid, Head of Communications or Julie Cooper (JC), Trust Secretary for their details to be included in this section.

The issue of Thames Valley University (TVU) was discussed. It was explained that this is a longstanding issue and the Trust's concerns were outlined. There have been numerous discussions with all parties concerned and the decision was not taken lightly. However the Chairman said that it is hoped that our actions will bring about positive changes in the future.

1.6 Chief Executive Report

Maternity

HL reported that the Healthcare Commission had undertaken a review of all maternity services. She said that we know that our antenatal service is good, but our postnatal service needs improvement. We now have a draft action plan which will serve as the basis for service improvements. Karin Norman, one of the Trust Non-Executive Directors has been asked to take a special interest in maternity. Council Representatives were invited to join the Maternity Review Task and Finish Group. It was noted that there is a 28% drop out rate for mothers, which presents a serious challenge in terms of capacity planning. We need to go beyond just providing a good clinical outcome to ensuring a positive overall experience for our mothers. There is a capacity issue in London. ML asked if we challenged the outcome of the review. HL responded that 14 criteria were challenged, and that many other Trusts did the same. The Healthcare Commission did not change the outcomes of the review as a result. The Foundation Trust Network also challenged the review but no changes came about. HL said that we are going to tailor the 'You Are the Difference' training to address the customer service needs around the

maternity service. ML said that we must stress that there are some excellent things going on in maternity. CE stressed it is a London-wide problem. PM said that speaking as a commissioner of the service, regardless of whether it is a London-wide problem the Trust must take heed of these findings. CBT asked who actually provides the postnatal care. HL said that we have introduced nursery nurses for breastfeeding mothers and we have trained surgical nurses from HDU on the ward. Healthcare assistants are being integrated into the team but there has been some difficulties. HL said that both her and the Director of Nursing have addressed staff directly and remain positive that they will learn from these findings and work to improve the service.

Action: Invite Council Members to sit on the Maternity Review Task Group.

Hygiene / Infection Control

CE said that Chelsea and Westminster has half the national average of MRSA and therefore we have a more challenging target. We had an unannounced visit from the Healthcare Commission and the outcome was good. They did make some recommendations, which will be implemented. We have had an outbreak of *C. Difficile*. All the necessary steps have been taken and symptomatic patients were isolated on one of the private wards. We have had daily briefings on the situation. All appropriate actions have been taken and although the outbreak is not yet over we feel we are on top of it. Norovirus has also been a problem. PM said that Chelsea and Westminster PCT are impressed with the actions of the hospital and they are confident that everything is being done to get the situation under control. CE noted that the spread of infection by *C. Difficile* is not well understood.

2. ITEMS FOR DECISION / APPROVAL

2.1 Business Planning

LB said that the Board had agreed the overall approach and five main objectives. She noted the key deliverables and rationale for each. She said that the guidance for directorates will be issued shortly which will allow them to develop and define their specific objectives. This paper is brought to the Members' Council significantly earlier than last year to ensure input on the approach as well as the objectives. She asked the Members Council to consider if the draft deliverables seem reasonable and will they help us deliver our objectives and to tell us if we have missed anything. LF raised the issue of the research strategy and asked if this was to be a shotgun approach or whether we would be targeting specific areas. CE said that there are certain areas where the trust has a reputation but we are also concerned with more general aspects of research. MS asked about teaching. CE confirmed that we get money for the specific responsibility of teaching. HL said that undergraduate teaching is important and it pays well and teaching attracts better staff. Teaching includes pharmacists and therapists and we work with the local Kensington and Chelsea college on NVQs. Ultimately, we aim to teach all levels as they all have a role to play in the health service. SBS asked if we had alternatives to TVU? AMC said we did and that a competitive process would be run to select a new provider. HL stressed that we offer excellent clinical placements and we will continue to do so. JB raised the issue of discharge planning and patients going home with wrong details on their charts which makes follow-up difficult. The limitations of the current ICT systems were explained and discussed. FT asked if we could not make better use of the building on the weekends. It was explained that with 18 weeks, staff are already working six days per week. CE said that he heard two key points from the discussion: 1/ it is important that opportunity and access to care is there when needed and 2/if we are looking at innovative delivery of care then we may need to do things differently. LB summarised the discussion. She said she understood that there was broad agreement on the objectives and groupings of deliverables and that deliverables should be clarified together with the timetable.

THE MEMBERS' COUNCIL AGREED TO THE OBJECTIVES AND GROUPINGS OF DELIVERABLES AND SUGGESTED THAT THE DELIVERABLES BE CLARIFIED.

2.2 Changes to the Constitution

CE said that the Council voted to move to an opt out system for staff membership at the last meeting. This move has raised some issues around staff constituencies. There was a proposal to move the management constituency into another category as there was a small number of staff and the seat on the Council remained vacant. It was also proposed to remove the sentence in

the constitution disqualifying volunteers from becoming staff members of the Trust. This was agreed. It was agreed that the issue of the staff categories would be left for further consideration.

IT WAS AGREED TO REMOVE THE SENTENCE IN THE CONSTITUTION DISQUALIFYING VOLUNTEERS FROM BECOMING STAFF MEMBERS OF THE TRUST. IT WAS AGREED THAT THE ISSUE OF THE STAFF CATEGORIES WOULD BE LEFT FOR FURTHER CONSIDERATION AND A DECISION.

2.3 Healthcare Commission Standards for Better Health

CM reported that a session was held with representatives from the Council on 28 January to review the Trust submission and for the Council to ask questions and query the evidence provided by the Trust. CM explained that the submission had been drafted as coming from the Members' Council. Further comments were invited. It was noted that p6 should read 'team dietician' not nutritionist. The issue of feeding patients was discussed and Council Members' queried the use of volunteers for feeding rather than this being seen as a core part of nursing duties. AMC responded that he was satisfied that when issues were raised about feeding we can address them. ML asked if patients are weighed. It was confirmed that patients are weighed and that we have new scales to ensure accuracy. The Council said that the point on the cost of waste disposal should be clarified and staff should be encouraged to use the appropriate bins.

THE COMMENTARY WAS AGREED WITH THE CHANGES NOTED ABOVE.

2.4 Membership Report

CE said that membership was becoming more important and this was made clear by Gordon Brown's statement that he wanted to see membership double by 2010. The slight drop in membership in both the patient and public constituencies as well as the increase in staff membership was noted. The question is whether we go into the community to recruit and this comes at a cost. Colin Glass, as the lead non-Executive Director for the Members' Council, was invited to contribute. He said that the Council would need to decide whether a blanket mailing to recruit new members with a positive response rate of 4% was cost effective. The Council felt it was better to find ways of increasing Council Member engagement within their membership constituencies and to promote membership this way. JB asked if we had contacted large voluntary organisations in the respective boroughs e.g. New Horizons, Age Concern. LF suggested we capture new members via GP surgeries. It was suggested that we target large employers in the area.

AD reported that we had elected Martin Rowell as Chairman of the Membership Development and Communications Subcommittee for one year after which time it will rotate annually. She reported that Jane Collier, Equality and Diversity Manager, had looked at Monitor's requirement for socio-economic reporting and felt that this could be improved. She suggested that we ensure members are involved in all of the existing user groups throughout the Trust. It was agreed that we pilot Membership Surgeries and Medical Lectures for Members be held on the Open Day and again at the Annual Members' Meeting. We received good feedback on the website and we agreed we must keep the information up to date. It was reported that the Communications Sub Group felt the Trust should have been more vocal in response to negative press articles.

Action: Send JC names of voluntary organisations and ideas to promote membership and involvement
Action: Ensure membership leaflets are available in local GP surgeries.
Action: Provide Council Members with membership promotion materials
Action: Include membership leaflets in discharge packs
Action: Provide membership leaflets to interested members for distribution

IT WAS AGREED THAT WE PILOT MEMBERSHIP SURGERIES AND MEDICAL LECTURES FOR MEMBERS AT THE OPEN DAY AND AGAIN AT THE ANNUAL MEMBERS' MEETING.

2.5 Open Day

MA reported that last year's Open Day was a success and we want to do something similar this year. Themes around health and well being and infection control will have a high profile. It is also the 60th Anniversary of the NHS and this will be celebrated as well. MA explained that the charity would only be funding part of the Open Day this year and that other sources of external funding were being identified. Council Members were invited to participate in both the Steering Group as well as the Open Day Operational Group.

Action: MA to circulate dates for these groups

2.6 Healthcare for London: Consulting the Capital

CE said that Healthcare for London: A Framework for Action has been brought to the Members' Council on various occasions. Diana Middleditch, Acting Chief Executive, Kensington and Chelsea PCT, gave a presentation on Consulting the Capital. DM highlighted many of the key issues being addressed in the consultation including access to doctors on evenings and weekends, women's right to choose where they have their babies, 60% of people having to wait to see consultants, cancer survival rates being lowest in Europe, sub-optimal stroke care and the lack of access to specialist care in certain areas. We know the demand on the service will grow and outstrip supply. Londoners having poor mental health and smoking rates being high was also highlighted. She stressed that the model is clinically-led and that it was felt 40% of hospital admissions could be dealt with in the community. The Members' Council responded that if this model is introduced, not even hospitals will do everything and that they understood the GP would be first port of call for urgent care. The Council liked the idea of PCTs investing in staying healthy and treating people earlier with a greater level of community care. ML wanted to know if we were to promote people dying at home if staff would be there to support them. The Council discussed applying the Darzi model to Chelsea and Westminster. The Council felt the model does not fit as we are both a generalist and specialist hospital. The importance of working with social services and ensuring joined up care was discussed. CE asked if the Council had an opinion on trading services and consolidating services in one place to ensure better clinical outcome. The Council felt services needed to be available and that there must be a real choice for patients amongst equal services.

Action: Include Members' Council comments in Trust response.

2.7 Chelsea and Westminster Duathlon

CE said that the Duathlon is taking place this September in Richmond Park and he encouraged all Council Members to get involved.

3.1 Finance Report – Month 9

CE said that he would take the paper as read and invited any comments. There were none.

3.2 Performance Report – Month 9

CE said that he would take the paper as read and invited any comments. There were none.

4. ANY OTHER BUSINESS

No other business was raised.

5. DATE OF NEXT MEETING – 8 May 2008
Signed by

Prof. Sir Christopher Edwards
Chairman
8th May 2008

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 8 May 2008

AGENDA ITEM NO.	1.4/May/08
PAPER	Matters Arising
AUTHOR	Julie Cooper, Foundation Trust Secretary
LEAD	Chris Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting(s) and the action taken/to be taken.
DECISION/ ACTION	The Members' Council is asked to note the matters arising and update where appropriate.

Matters Arising from Previous Meetings

Reference	Item	Action
1.6/Feb/08	CHIEF EXECUTIVE'S REPORT Invite Council Members to sit on the Maternity Review Task Group.	HL
2.4/Feb/08	MEMBERSHIP REPORT 1. Send JC names of voluntary organisations and ideas to promote membership and involvement 2. Ensure membership leaflets are available in local GP surgeries. 3. Provide Council Members with membership promotion materials 4. Include membership leaflets in discharge packs 5. Provide membership leaflets to interested members for distribution	ALL ALL JC JC JC
2.5/Feb/08	OPEN DAY MA to circulate dates for steering group and operation group.	JC
2.6/Feb/08	HEALTHCARE FOR LONDON Include Council comments in the Trust response.	JC

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 8 May 2008

AGENDA ITEM NO.	1.6/May/08
PAPER	Chief Executive's Report
AUTHOR	Julie Cooper, Foundation Trust Secretary
LEAD	Chris Edwards, Chairman
EXECUTIVE SUMMARY	This report outlines key issues for the attention of the Members' Council.
DECISION/ ACTION	The Members' Council is asked to note the report.

CHIEF EXECUTIVE'S REPORT

1.0 NIHR COLLABORATIONS FOR LEADERSHIP IN APPLIED HEALTH RESEARCH AND CARE (CLAHRC)

1.1 I am pleased to be able to report that the Trust has been successful in its bid to become a Collaboration for Leadership in Applied Health Research and Care (CLAHRC). Only seven of the 12 bids were successful and ours is the only one in London at this stage.

1.2 The bid is for matched funding of £18 million.

1.3 The uniqueness of the bid is due to the wide range of partners – Imperial College, Dr Foster, NHS Centre for Innovation, as well as the other NHS organisations within North West London.

1.4 The research will focus on the effectiveness of implementation of best practice chronic disease management and clinical care.

1.5 Professor Derek Bell should be congratulated on his leadership in securing this bid.

1.6 The financial commitment by the Trust has been factored into the budget for 2008/09.

1.7 A unique feature of the bid is the opportunity for the public to be involved and in particular the Members' Council

2.0 CHIEF EXECUTIVE DEVELOPMENT PROGRAMME – LEADING FOR HEALTH, LONDON STRATEGIC HEALTH AUTHORITY

2.1 Amit Khutti, Director of Strategy and Service Planning and Debbie Richards, General Manager of the HIV/GUM Directorate, have been selected for the NHS London Leadership development programme for aspirant CEOs within a three to five year time scale.

2.2 The assessment process was rigorous. Each candidate undertook psychometric tests (verbal and numerical), an observation day, submitted a portfolio of evidence followed by an interview.

3.0 PAEDIATRICS IN NORTH WEST LONDON (NWL)

The NWL PCTs will be issuing a service specification for specialist paediatrics encompassing paediatric and neonatal surgery with the aim of centralising these services on to one site together with a paediatric intensive care unit. The specification will be issued in late June with bids to be in probably by mid September. This is strategically very important to this Trust and represents significant risks that are wider than just paediatrics. The Trust is working to provide a strong bid and to mitigate risk.

4.0 COMMISSIONING IN LONDON

4.1 NHS London is reviewing how commissioning can be strengthened and has engaged McKinsey to help. Providers will have the opportunity to contribute to the work.

5.0 COMMISSIONING IN KENSINGTON AND CHELSEA, HAMMERSMITH AND FULHAM AND WESTMINSTER

5.1 The three PCTs have formed a collaboration to strengthen their commissioning with the providers.

6.0 HEALTH AND SOCIAL CARE AWARDS

6.1 Chelsea and Westminster Hospital together with Kensington and Chelsea Social Services was shortlisted for the strategic partnership work for vulnerable adults. George Greener, Chairman for London SHA commended the scheme for the way in which dignity had been approached

7.0 POLYCLINICS

7.1 Last month I was invited to Downing Street to take part in a discussion with Greg Beales, the Prime Minister's Health Advisor, on how Foundation Trusts can expand their services into primary care where this is in the interests of the Trust and is likely to deliver better health outcomes.

7.2 In particular the Prime Minister would encourage Foundation Trusts to spearhead a much greater and tangible focus on prevention and personalised healthcare.

7.3 We have now been offered the opportunity to go forward to prepare a 'catalyst' project.

7.4 Proposals should have:

1. A preventative focus and offer greater integration with primary or community care.
2. Be of a scale likely to achieve significant change in their respective health economies.
3. Be innovative.

8.0 BARIATRICS BID

8.1 Our Trust has been successful in our bid to be selected as a 'preferred provider' of bariatric (obesity) surgery.

8.2 The South East Coast Specialist Commissioning Group (SCG), which is leading a project to identify the best hospitals to carry out this specialist surgery in London, the South East Coast region and in the East of England, chose Chelsea and Westminster following a visit to the hospital by a review team – their decision is due to be formally ratified by the other SCGs in the near future. We have been informed that this ratification should be a formality.

8.3 The review team will not confirm as yet which other Trusts have been selected as preferred providers, although we do know that Imperial Healthcare NHS Trust has also been successful in its bid.

8.4 The ‘preferred provider’ status will not automatically stop PCTs from commissioning bariatric surgery from other Trusts, but we would expect PCTs to increasingly rely on this list of preferred providers when making commissioning decisions.

8.5 In 2007 we performed just under 150 bariatric surgical procedures. With the appointment of a new bariatric surgeon in 2007 (Mr Gianluca Bonanomi) a new Clinical Nurse Specialist in Bariatrics (Nuala Davison) and associated equipment we believe he have the capacity to perform over 250 procedures in 2008 and are planning on this basis.

8.6 We have sent out a letter to GPs in adjoining PCTs informing them of our selection as a preferred provider, and are planning further promotional activity including articles in the local press and GP seminars on our bariatric service.

Heather Lawrence
Chief Executive
May 2008

Members' Council Meeting, 8th May 2008

AGENDA ITEM NO.	2.1/May/08
PAPER	Financial and Corporate 2008/09
AUTHOR	Lorraine Bewes, Director of Finance and Information
LEAD	Lorraine Bewes, Director of Finance and Information
SUMMARY	The membership and the Members' Council play a vital role in providing a community perspective to service development. The Annual Plan sets out a clear and shared vision amongst staff, members and external stakeholders of how the Trust and individual directorates will develop over the next 12 months. This paper is not the final corporate plan. The final plan with directorate specific objectives will be available to the Members' Council following the next Trust Board meeting. This paper aligns the corporate objectives with the now agreed revenue and capital budgets. It also sets out the savings plan (CIPs) and funded developments. A number of key objectives have been set out to demonstrate the link between the financial plan, directorate objectives and corporate objectives.
DECISION/ ACTION	The Council is asked to note this paper.

FINANCE AND CORPORATE PLAN 2008/09

1. Introduction

1.1 In previous meetings the Board has approved the Trust wide key corporate objectives, the principles and assumptions underpinning the budget setting for 2008/09 and approved the overall income and expenditure budgets, a corporate efficiency target of 4.4% and a plan to maintain a level 5 risk rating with Monitor. A separate paper was also tabled proposing principles and priorities for the Trust's capital investment strategy and programme.

1.2 These plans were subject to the completion of detailed business planning bilaterals with directorates which have now been concluded. The Board also asked for the capital programme to come back for final approval.

1.3 Therefore the purpose of this paper is to confirm to the Board the corporate objectives and plans at directorate level and to give assurance that appropriate revenue and capital financial resources are budgeted for 2008/09 at Trust and directorate level.

2. Corporate Objectives

2.1 The Trust has consulted with the Members Council on the key corporate objectives for 2008/09 and agreed them. The Board will recall that there are five key themes:

1. Focus on patient safety and quality
2. Deliver effective and efficient pathways of care
3. Be the provider of choice
4. Deliver excellence in teaching and research
5. Create robust infrastructure for the future

2.2 The associated deliverables for 2008/09 are:

1. Focus on patient safety and quality
    a. Achieve consistent improvement as benchmarked through best practice
    b. Deliver target reductions in healthcare acquired infections
    c. Maintain CNST level 2 and make progress towards CNST level 3
2. Deliver effective and efficient pathways of care
    a. Deliver the 18 weeks target in full by December 08 then sustain performance and identify areas where we can go further
    b. Work in partnership with PCTs to deliver recommendations from the consultation on Healthcare for London: A Framework for Action
    c. Introduce case-management of patients
    d. Achieve key financial targets
3. Be the provider of choice
    a. Improve patient satisfaction
    b. Redefine and develop the 'Chelsea & Westminster Offer' to staff
    c. Secure a larger patient base for the Trust in collaboration with PCTs and other providers

4. Deliver excellence in teaching and research
    a. Deliver excellence in teaching
    b. Implement the research strategy
    c. Lead a Collaboration for Leadership in Applied Health Research and Care
5. Create robust infrastructure for the future
    a. Provide excellent administrative processes for elective patient pathways
    b. Ensure services have strong clinical leadership and managerial and corporate support to enable increased devolution of responsibility to front line services
    c. Maintain robust governance and assurance processes
    d. Agree and approve a migration path from Lastword to an alternate system

2.3 The Board has already seen the draft overall corporate plan. The Executive has now met with all directorates and agreed draft corporate objectives in line with the 5 overarching themes. The key highlights are set out in the following section. The full corporate plan with directorate business plans as appendices will be circulated before the May Board meeting and this will include in addition to this paper:

1. Review of 2007/08
2. Summary of Objectives and Business Plans for developments
3. Risk assessment.

2.4 As an FT the Trust is required to sign off its corporate plan with a 3 year financial plan with Monitor by the 30th May and this is scheduled for approval at the May Board.

2.5. The key objectives in the directorate business plans are as follows:

2.6. Anaesthetics and Imaging Directorate

- Improve theatre and Treatment Centre productivity and efficiency.
- Support the creation of the joint female surgical ward.
- Undertake marketing of appropriate services for example TSSU.
- Improve procurement across all theatres to realise savings and economies of scale.
- Develop the Hand Management Service.
- Develop a Balloon Kyphoplasty service in Imaging.
- Introduce a dedicated cardiac nuclear medicine (MPI) service.
- Ensure ITU is as responsive and efficient as possible.

2.7 HIV and GUM Directorate

- Continue to improve access for hard to reach groups, reduce levels of sexually transmitted infection and increase early diagnosis of HIV.
- Relocate Victoria Clinic to new premises in Soho.
- Enhance out patient, inpatient and day care services for HIV positive care.
- Ensure that 18WW target is met and data is complete and robust.
- Continue to achieve GUM 48-Hour Access target (100% offered) and reduce the gap between offered and seen (95%).
- Expand sexual health services' market share by achieving GUM growth of 10% and HIV growth of 13%.
- Maximise and support our teaching/academic/clinical research opportunities with our partners.
- Replace GUS.
- Continue to enhance call centre service.
- Improve accuracy and timeliness of clinical coding and activity data recording, reporting and quality.
- Continue to provide an excellent specimen reception centre and laboratory service to the directorate (HIV) and SSAT to support research and exploit opportunities for income generation.

2.8 Medicine Directorate

- Develop and secure an inpatient Sleep Studies service.
- Further develop outpatient/community models of care to reduce unnecessary hospital appointments and stays.
- To improve the prevention of stroke/TIA through timely detection and effective management of patients at risk by managing risk factors in line with clinical guidelines.
- To achieve 95% on 12 Performance Indicators for National Sentinel Audit for Stroke 2008.
- To meet the internal and external Neurophysiology target for 4 and 6 weeks.
- Ensure that the Directorate meets and maintains its statutory obligation under EWTD for doctors in training.
- To continue the redesign of the Cardiology ECG Outpatient service to improve efficiency and maximise patient care.
- Undertake review of the Dermatology service.
- Deliver and maintain the 18 week wait target throughout 2008/09 through patient flow and pathway redesign for elective patients.

- To improve the pathway for acute medical patients by streamlining admission through A&E and AMU; making the transfer of consultant care explicit and timely; and explore the options available to expedite delayed discharges into the community.

2.9 Surgery Directorate

- Deliver and maintain the 18 week wait target throughout 2008/09 through patient flow and pathway redesign for elective patients.

- Fully roll out Service Line Reporting to ensure all income is captured and utilise to expand services and improve efficiency.

- Develop the emergency surgery pathway, focusing on providing prompt, safe and timely care and reducing the emergency length of stay and unnecessary theatre delays.

- To review the process of elective admissions in order to streamline the patient pathway.

- Ensure that the Directorate meets and maintains its statutory obligation under EWTD for doctors in training.

- Develop the role of nursing staff to increase skills and flexibility and reduce the reliance on bank and agency staff.

- Develop and expand specialist services.

- Support the creation of the joint female surgical ward with gynaecology.

2.10 Women and Children's Directorate

- Achieve EWTD targets on medical rotas.

- Develop Service Line Reporting.

- Develop and implement Maternity Service Action Plan.

- Achieve 60 hour cover for Maternity.

- Implement Private Maternity expansion.

- Develop bid for Specialist Paediatrics in North West London.

- Develop and implement permanent infrastructure to support 18 weeks delivery for Paediatrics.

- Develop and implement permanent infrastructure to support 18 weeks delivery for Gynaecology.

- Implement permanent infrastructure in NICU to support activity levels and PMU expansion.

- Support the creation of the joint surgical ward with surgery.

- Undertake marketing of appropriate services for example TSSU.

2.11 Support Services Directorate

Estates and Facilities

- Strengthen the Health and Safety agenda within the Trust, ensuring that robust governance arrangements are in place to safeguard the wellbeing of patients, staff and hospital visitors.

- Refine the Estates Strategy to ensure that it underpins future clinical activity projections, including the potential paediatric rationalisation and increasing single room provision.

Pharmacy

- Reduce outpatient waiting times for prescriptions.

- Deliver effective and efficient pathways of care for inpatient prescribing.

Therapies

- Support front line directorates with the implementation of new therapy services such as the pulmonary rehabilitation service.

2.12 Corporate Directorates

CEO

- To work with the Members' Council to ensure that their views are taken into account in setting the Trust's strategic direction and to continue to build the Trust's membership.

Nursing

- Implement the Saving Lives Care Bundles to help reduce infection rates and achieve the C.difficile and MRSA stretch targets.

- Undertake a programme of real time patient surveys.

HR

- Achieve compliance with the August 2009 EWTD for all doctors in training.

- Focus on increasing employee engagement to encourage the development of a workforce of inspired employees willing to contribute additional discretionary effort.

Finance

- Develop the provision and use of service line reporting and develop monthly service line reports.

- Prepare for the adoption of IFRS accounting from 2009/10.

- Improve the effectiveness and responsiveness of information provision to the Trust, especially the development of regular update of capacity plan (quarterly) and the provision of 18 week real time PTLs and referrals tracking.

- Achieve 100% coding within 7 days and improve the accuracy of coding measured by regular audit.

IM&T

- Maintain the Electronic Patient Record Services systems and software until an alternative set of systems can be implemented particularly LastWord, GUS and CMIS Maternity. Replace end of life software suppliers by adopting escrow and maintaining both hardware and software.

- Provide 24/7 system and service support to the Trust and outlying sites.

3. Final Revenue Plan for 2008/09

Following completion of the directorate bilaterals the detailed revenue and capital plans have been further assessed. The Executive has reviewed proposed developments and efficiency savings and can give the Board assurance that these plans support delivery of the key government target areas such as infection control, patient experience surveys and access targets, key Trust developments and support achievement of full EWTD compliance for 2008 including an increase from 40 to 60 hours obstetric cover in labour wards.

Since the last report we have finalised directorate cost pressures and developments, completed a review of the reserve commitments to be carried forward and have released £7.4m towards new year cost pressures and developments. As a result we have reviewed the efficiency requirement down, which is dealt with in the next section.

The revenue plan is summarised in Table 1 below, which includes a comparison with the high level plan reported last month, to highlight the key changes.

Appendix 1 sets out the starting approved budgets of £257.776m by directorate.

Appendix 2 details the build up of the income plan of £265.748m

Appendix 3 details the cost pressures and developments funded and reserved, viz

	£m
2007/08 cost pressures	1.753
2008/09 cost pressures/developments	6.345
2008/09 general reserve	2.272

High Level Resource and Expenditure Assumptions **Table 1**

	Last Report	Final	Change
	£000	£000	£000
Income Forecast 2008/09 net of Efficiency Saving	265,748	265,748	0
less Target Surplus for 2008/09 to retain 5 star rating	7,972	7,972	0
Resources available	257,776	257,776	0
Expenditure Forecast			
Current rollover expenditure budgets 2008/09	236,290	228,934	7,356
Depreciation 2008/09	8,026	9,065	-1,039
PDC Dividend 2008/09	8,687	8,687	0
Net Interest Receivable 2008/09	-1,000	-1,000	0
2007/08 Cost Pressures	2,630	1,753	877
Rollover Expenditure Requirements	**254,633**	**247,439**	**7,194**
Central Reserves for 2008/09			
Generic Inflation			
Pay	3,890	3,890	0
Drugs check inflation requirement	1,028	1,028	0
Other Non Pay	1,642	1,350	292
New High Cost Drugs	1,800	1,800	0
Baseline Expenditure 2008/09	**262,993**	**255,507**	**7,486**
Less Savings target	-8,217	- 6,348	-1,869
Baseline Budget (see Starting Budgets)			
2008/09 Cost Pressures and Developments			
Cost Pressures and Developments	3,000	6,345	-3,345
Reserve for Income loss/Contingency		2,272	-2,272
Current Budget Approvals	**257,776**	**257,776**	**-**

4. Efficiency Targets

4.1 Directorates were asked to prepare their Business Plans for 2008/09 with an indicative target of 4.5% for efficiency savings.

4.2 As a result of the release of reserves towards new year cost pressures and developments, the CIP requirement could be reduced from £8.217m (4.4%) to £5.223m (2.8%). However, the Board will recall from last year's strategic plan and risk assessment, that there is a potential threat to income levies for SIFT and MFF over the next 3 years. Whilst there are no concrete proposals that we can model, given the potential size of the impact, it would be prudent to begin to make provision against this possible loss while we can.

4.3 The SIFT income budget for 08/09 is £13m (including £1.1m invoiced to Imperial College Healthcare Trust for pathology teaching) for 155 FTEs, i.e. £84k per FTE. The national average is £35k per FTD and it is likely that the DH will redistribute this funding in line with the average. Therefore a worst case scenario could see a drop in income of c£7m. It is likely that this would be phased over a number of years but it would be prudent to assume a 20% reduction in 2009/10 i.e. £1.5m.

4.4 The MFF levy is budgeted at £42.3m and reflects an uplift of 40.2% on tariff based income to compensate us for the geographical costs of living in London. There has been constant pressure to review the MFF, particularly in the light of the agreement of a new national pay contract, Agenda for Change. Several years ago the levy was reviewed resulting in a capped 2% fall in the MFF levy. If this were to be repeated this would present a potential loss of £0.84m. We are aware that the DH is reviewing the MFF levy with potential impact in 2009/10.

4.5 Based on the above, it is proposed to maintain the CIP requirement at 3.5% to start to build up reserves against these income losses. A 3.5% CIP target delivers the level 5 financial risk rating and a general reserve of £2.2m.

4.6 Table 2 shows the progress with identifying cost improvement initiatives to date together with the risk assessment. Details of the schemes are available on request. In summary, 95% of schemes have been identified against the overall savings requirement of £6.348m. Any schemes identified in excess of a directorate's in year requirement will be credited towards their next year target.

Risk Assessment of Identified Savings **TABLE 2**

Directorate	Efficiency target		High	Medium	Low	Total
	Original	Proposed 3.5%				
Fac & Ops	755,000	597,000		479,000		479,000
Medicine & A&E	1,398,000	921,000	42,000	273,000	329,000	644,000
HIV/GUM	1,854,000	381,000			589,209	589,209
Imaging & Anaesthetics	1,191,000	866,000	405,900	135,698	153,849	695,447
Surgery	860,000	618,000	195,000	525,000	75,000	795,000
Women and Children	1,587,000	1,190,000	395,000	326,000	475,000	1,196,000
Pharmacy	170,000	136,000			115,452	115,452
Therapies	0	169,000	113,000	78,000	65,000	256,000
Man Exec	401,000	470,000		250,000		250,000
Corporate	0	1,000,000		1,000,000		1,000,000
	8,216,000	**6,348,000**	**1,150,900**	**3,066,698**	**1,802,510**	**6,020,108**
						95%

5. Capital Plan

6.1 The Board received a paper at the last meeting setting out the principles and priorities for the Trust's capital investment strategy. It explained the available sources of finance for capital investment for 2008/09 and proposed an initial capital programme. The proposals have been updated in the light of directorate bilaterals and the final outturn for 2007/08 and the strategy, principles and programme are represented for approval. The detailed scheme analysis is available on request.

6.2 Capital Investment Strategy

The capital investment strategy needs to support the Trust's strategic development objectives by ensuring that:

a) The asset base is kept up to date and replaced as useful lives are reached in order to avoid technical obsolescence and minimise risks, especially those highlighted on the Trust's risk register;

b) The asset base is aligned to deliver the Trust's planned developments arising from its corporate objectives.

6.3 Therefore the priorities for capital investment in 2008/09 will be to:

a) Fund prior commitments for capital projects commenced in prior years;

b) Fund assets that are essential to ensure clinical safety, especially to address items highlighted on the risk register, after all possible alternatives have been considered. This may include replacement of out-of-life equipment;

c) Maintain and enhance the fabric of the building;

d) Fund assets to facilitate strategic service developments;

e) Fund assets that are essential to deliver key performance targets, and productivity/efficiency benchmarks are already within the upper quartile and all possible alternatives have been considered;

f) Fund 'invest to save' initiatives, with clear evidence that savings will be made;

g) Fund assets essential for growing a service, where there is clear evidence of increased demand and it is clear that the contribution the service makes to the Trust will increase sufficiently to offset the effect of the initial investment.

h) Fund assets to address key identified risks.

6.4 As part of the Business Planning process, budget holders have been asked to submit their capital bids in line with the priorities above.

6.5 Sources of capital funding

6.6 The sources of funding for capital investment in 2008/09 are set out in detail in Table 3 below. The Board will note that we have built up significant resources for the future strategic development of the Trust and it is regarded as prudent to make full use of our existing borrowing capability in order to maximise development funds for the Trust.

6.7 Table 3 shows that the maximum available resources for the capital programme are £54.2m, subject to finalising the outturn for 07/08. The proposal is to utilise the internal resources available of £39.9m first and to apply for a further loan from the Foundation Trust Financing Facility if further funds are required, in the event that the paediatric tertiary centre bid is agreed (See 6.10 and 6.11 below).

TABLE 3

FUNDING SOURCES FOR CAPITAL INVESTMENT

	@ 3rd April 08 FY 08-09 £000	**FINAL FY 08-09 £000**
Surplus cash for capital b/fwd	2,813	11,250
Depreciation	8,590	9,065
Income & Expenditure reserves b/fwd 31.03.07	5,030	5,030
Forecast Net Surplus to 31.03.08	12,142	14,625
Internal resources available for capital programme	**28,575**	**39,970**
Prudential Borrowing Limit Maximum Borrowings	14,275	14,275
Maximum resources available for capital programme	**42,850**	**54,245**
Proposed Capital Expenditure	**(19,839)**	**(28,465)**
Surplus cash for capital c/fwd	**23,011**	**25,780**

6.8 The sources available for funding capital investment have increased by £11.4m from the last report due to slippage on the 2007/08 programme (but this is matched by increased commitments in 2008/09), increase in depreciation and an improvement of £2m in the final net surplus position.

6.9 The Board is reminded that as part of the Trust's authorisation as a Foundation Trust in October 2006, the Trust took out a £12.5m loan from the Foundation Trust Financing Facility to fund part of the Trust's capital programme in 2006/07 and 2007/08. All of this finance facility was utilised by 31st March 2008. Therefore the Trust's accumulated reserves from prior to 1st April 2007 are available in 2008/09 for capital investment. The Public Dividend Capital received in 2007/08 was to part fund the PACS system which was implemented last year.

6.10 The Trust will be making a submission to the NW London Commissioners this summer in respect of centralising tertiary paediatrics and if we are successful, we would need to be in a position to proceed in the autumn to develop significant additional paediatric facilities. It is estimated that we would need c£25m for stage 1 of the development.

6.11 It is therefore proposed that the Board approves an initial capital programme budget to proceed with must do building works, equipment and IT and approved business cases and develop business cases for further capital bids to hold for appraisal in the autumn in the context of strategic decisions on the siting of the tertiary paediatrics centre.

6.12 The Board should note that the Trust does not index its asset base each year as it did as an NHS Trust but is required to carry out an independent valuation at least every 3 years. The last asset valuation was carried out on 1st April 2006 and the next valuation will be on 1st April 2009, impacting on accounts for 2009/10. Therefore part of the surplus in 2007/08 and 2008/09 will derive from the fact that prices have been uplifted for indexation but will not impact on the asset base until 2009/10. This will be planned for in our 3 year forward plan. Therefore within the retained surplus for 2007/08 of £14.1m approximately £1.5m is non-recurrent and potentially £1.9m of our planned surplus for 2008/09 of £8m is also non-recurrent.

4. Final Capital Programme

7.1 Through the Business Planning process, bids totalling £33.6m have been received. The Capital Programme Board has reviewed these bids against the corporate planning objectives and the priorities listed in section 6.2 and 6.3.

7.2 The Capital Programme Board has considered capital requirements arising from extant risks on the risk register and is satisfied that provision has been made in the proposed capital programme to address these.

7.3 The Capital Programme Board has also considered the 5 year backlog maintenance schedule to maintain the site at Condition B status. As at the beginning of 2008/09, approximately £3.8m is required in 2008/09 to reduce backlog maintenance and all of this has been provided for in the programme. This leaves a further £6.9m to be addressed over the next 4 years.

7.4 The Capital Programme Board proposes for approval an initial capital programme budget of £28.464m to proceed with must do building works, equipment and IT and approved business cases, leaving scope for financing the paediatrics tertiary centre if approved this summer. A summary is set out in Table 4 below:

Capital Programme 2008/09 **Table 4**

	Total Capital Bids & Carry forward Presented	**Total Bids Recommended for Approval**
Building Projects	12,597,000	12,417,000
Building Projects - Awaiting Business Case	7,847,220	5,807,220
Equipment	6,875,476	5,965,925
IT	5,798,500	3,774,500
Contingency	500,000	500,000
Total Capital Programme	**33,618,196**	**28,464,645**

7.5 The split between c/fwd commitments from 2007/08 and new developments for 2008/09 is set out in Table 5.

Capital Programme 2008/09 **Table 5**

	C/Fwd commitments 2007/08	New Bids 2008/09
Building Projects	6,625,000	5,792,000
Building Projects - Awaiting Business Case	-	5,807,220
Equipment	3,465,925	2,500,000
IT	465,500	3,309,000
Contingency	-	500,000
Total Capital Programme	**10,556,425**	**17,908,220**

5. CONCLUSIONS AND RECOMMENDATIONS

The Board is asked to:

a) Note and approve the Directorate corporate objectives.
b) Approve the final revenue plan, noting the reduced corporate efficiency target of 3.5%, reserved developments and provision for future income loss.
c) Approve the capital investment strategy and capital programme of £28.5m outlined in the paper and delegate budget approval and progress monitoring to the Capital Programme Board.
d) To note that this leaves c£25m unutilised funds from internally generated sources and financing, which will be further appraised in the autumn following decisions on the tertiary centre for paediatrics.

Lorraine Bewes
Director of Finance and Information
23.04.08

Starting budgets 2008/09 **APPENDIX 1**

Directorates	Pay £000's	Non Pay	Sub Total	2007/08 Cost Pressures	Sub Total	Cost Pressures	Total	Efficiency Savings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
A&I	21,551	4,999	26,550	276	26,826	698	27,524	(866)	26,658
HIV	12,020	30,297	42,317		42,317	67	42,384	(381)	42,003
Medicine	24,557	7,979	32,536	87	32,623	168	32,791	(921)	31,870
Surgery	15,013	4,335	19,348	435	19,783	801	20,584	(618)	19,966
W&C	33,225	4,634	37,859	458	38,317	562	38,879	(1,190)	37,689
Pharmacy	4,329	319	4,648	17	4,665	43	4,708	(136)	4,572
Therapies/Dietetics	4,827	159	4,986	26	5,012		5,012	(169)	4,843
Chief Exec	1,024	167	1,192	30	1,222		1,222		1,222
Governance	822	3,280	4,103	9	4,112		4,112		4,112
Nursing	2,447	187	2,634		2,634	119	2,753	(54)	2,699
Human Resources	1,553	185	1,739	11	1,750	118	1,868		1,868
Finance	3,965	828	4,793		4,793	279	5,072	(258)	4,814
Information Tech	2,296	2,262	4,559		4,559		4,559	(159)	4,400
Occupational Health	373	58	430		430		430		430
Facilities	249	17,612	17,861		17,861	183	18,044	(568)	17,476
Operations	1,081	7	1,088		1,088		1,088	(28)	1,060
Adult PP	1,003	484	1,487	404	1,891		1,891		1,891
Overseas Patients	36		36		36		36		36
ACU	794	440	1,234		1,234		1,234		1,234
PGME	312	103	415		415		415		415
Projects	879	70	948		948		948		948
Sim Centre / Clinical Skills	447	66	513		513		513		513
SLAs		14552	14,552		14,552		14,552		14,552
Reserves		3,108	3,108		3,108		3,108		3,108
Total Directorates	132,801	96,132	228,934	1,753	230,687	3,038	233,725	(5,348)	228,377
Central budgets									0
Depreciation		9,065	9,065		9,065	1,404	10,469		10,469
PDC Dividend		8,687	8,687		8,687		8,687		8,687
Net interest receivable		(1,000)	(1,000)		(1,000)		(1,000)		(1,000)
Reserves & Provisions							0		0
High Cost Drugs		1,800	1,800		1,800		1,800		1,800
Generic Inflation	3,890	2,378	6,268		6,268		6,268		6,268
Other developments						1,903	1,903		1,903
General Contingency						2,272	2,272		2,272
Corporate Efficiencies								(1,000)	(1,000)
	136,691	117,062	253,754	1,753	255,507	8,617	264,124	(6,348)	257,776

Analysis of Income Plan

Appendix 2

Description	Total Budget 07-08	Forecast Outturn 2007/08 as at M10	Forecast 2008/09	Change from out-turn
	£	£	£	£
SLA Contracts with PCTs	(121,590,556)	(121,590,556)	(124,676,213)	3,085,657
NEL Threshold Impact			593,000	
GUM				
Pct Over Performance	(3,182,552)	(4,972,417)	0	(4,972,417)
Pct Under Performance	1,933,591	4,817,082	0	4,817,082
HIV	(43,105,902)	(43,639,284)	(45,316,899)	1,677,615
HIV Overperformance	(1,214,015)	(476,485)	0	(476,485)
Nicu Consortium Income	(4,596,978)	(4,173,512)	(4,722,140)	548,628
Burns Consortium	(2,358,223)	(2,137,104)	(2,081,346)	(55,758)
High Cost Drugs	68	11,635	(1,804,602)	1,816,237
2003-2004 Deficit Payback	(2,204,000)	(2,204,000)		(2,204,000)
Prior Year Balances	0	35,322		35,322
Subtotal Contract Income	**(176,318,567)**	**(174,329,320)**	**(178,008,200)**	**4,271,880**
Non Contract Activity & Over Seas	(2,382,777)	(2,189,975)	(2,776,726)	586,751
NHS Prescription Income	(93,831)	(124,325)	(127,184)	2,859
Road Traffic Accident Income	(347,700)	(377,701)	(386,388)	8,687
Non DoH Overseas Visitors	(753,480)	(791,310)	(809,000)	17,690
Provider To Provider Diagnosti	(112,337)	(186,030)	(190,000)	3,970
Provider To Provider Sla- Brom	(235,553)	(235,548)	(241,000)	5,452
Provider To Provider SLA Clini	(150,818)	(157,740)	(161,000)	3,260
AHP Services	(49,055)	(67,368)	(69,000)	1,632
Provider To Provider ITU/HDU services	0	(17,684)	(18,000)	316
SLA Work in Progress	0	(116,219)	(119,000)	2,781
Cost Per Case	(102,156)	(115,306)	(118,000)	2,694
Other Income	(1,650,894)	(296,273)	(336,499)	40,226
HIV Drugs		(1,058,101)	(1,058,101)	0
HIV research		(213,000)	(213,000)	0
Salary recharges- Kobler staff		(165,400)	(165,400)	
Market Forces Factor	(39,621,002)	(41,796,144)	(42,307,000)	510,856
Pbr Clawback	6,428,000	6,428,000		6,428,000
Subtotal Other Clinical Income Including MFF	**(39,071,603)**	**(41,480,125)**	**(49,095,299)**	**7,028,423**
Occupational Health Service -	(133,415)	(110,752)	(113,300)	2,547
Distinction Awards	(864,948)	(864,940)	(877,922)	12,982
Income From Training Sessions	(329,894)	(284,949)	(291,503)	6,554
Income From Sponsors	(334,237)	(629,988)	(334,237)	(295,751)
Income From Catering Services	(427,368)	(440,820)	(450,959)	10,139
Income From Patients Hotel	(6,648)	(1,416)	(1,416)	0
Income From Car Parking Fees	(245,784)	(401,735)	(401,735)	0
Income From Rooftop Aerials	(7,188)	(1,558)	(1,594)	36
Income From Cash Service Till	(9,412)	(13,043)	(13,343)	300
Income From Room Hire	(9,228)	(15,803)	(16,166)	363
Income From Purchasing Arrange	(48,075)	(98,861)	(49,181)	(49,681)
Donated Depreciation Income	(260,004)	(308,577)	(260,004)	(48,573)
Miscellaneous Non Nhs Income	(400,674)	(757,055)	(419,506)	(337,550)
Clinical Trials Income	(49,080)	(78,588)	(49,080)	(29,508)
Grant	(6,000)	(12,000)	(6,000)	(6,000)
Income From Medical Records	(30,760)	(27,795)	(28,435)	639
Private Therapy Services	(32,040)	(16,963)	(17,353)	390
Charitable Funds Income	(78,832)	(127,528)	(78,832)	(48,696)
Provision Of Payroll Service	(241,482)	(292,555)	(179,440)	(113,115)
Critical Care Network Planning	(211,350)	(211,350)	(216,211)	4,861
Tissue Viability	(37,500)	(49,091)	(38,363)	(10,728)
Transplant Co-Ordinators	(659,657)	(718,828)	(735,361)	16,533
Provider Sift Income	4,980	0		0
Facilities Recharges	(1,453,809)	(1,640,675)	(1,487,247)	(153,428)
Pharmacy Services	(496,360)	(496,360)	(507,776)	11,416
Provider Sift Income	(12,624,480)	(12,809,466)	(12,965,341)	155,875
Provider Madel Pensions	(600,800)	0		0
R&D Specialist Projects	(2,891,566)	(2,891,569)	(1,703,909)	(1,187,660)
Nmet Income	(630,912)	(632,306)	(646,685)	14,378
Madel - Split Funding	(6,887,491)	(7,140,428)	(6,990,803)	(149,625)
Madel - Flexible Trainees	(318,724)	(354,483)	(323,505)	(30,978)
Madel - Pgme	(651,286)	(655,028)	(667,568)	12,540
CLARHIC Bid		0	(245,000)	245,000
Salary Recharge - Medical	(2,267,846)	(1,519,635)	(1,562,185)	42,550
Salary Recharge - Non Medical	(757,538)	(878,146)	(778,749)	(99,397)
Grand Total Other Non Clinical Income	**(33,999,408)**	**(34,482,293)**	**(32,458,707)**	**(2,023,586)**
Prescription Income	(56,557)	(179,205)	(187,628)	8,423
Self Funded Acu Income	(1,085,767)	(1,254,895)	(1,313,875)	58,980
Private Maternity Transfer			1,000,000	
Private Inpatient Services	(6,093,838)	(4,991,772)	(5,226,385)	234,613
Private Outpatient Services	(330,472)	(437,815)	(458,392)	20,577
Grand Total Private Patient Income	**(7,566,634)**	**(6,863,687)**	**(6,186,280)**	**322,593**
			0	0
Total All Income	**(256,956,212)**	**(257,155,425)**	**(265,748,486)**	**9,599,310**

Cost Pressures Approved at Bi- Laterals

APPENDIX 3

	Approved Phase 1	Bi-lateral Meetings		Total Approved
		Approved funding	Reserved	
Frontline Directorates				
A&I				
MSSE - historical budget pressure		96		96
MSSE increase in activity		173		173
MSSE leases		58		58
MSSE maintenance		16		16
Prosthetics - historical budget pressure		13		13
Increase in activity/historical budget pressure		43		43
catering historical budget pressure		35		35
Laboratory equipment/materials		17		17
Increase in activity due to opening additional theatre		53		53
Increase in laundry activity by ISS/infection control		39		39
Stationery - historical budget pressure		12		12
Hire of special beds		4		4
Anaesthetic Practitioner - charities to share funding @ 50%		82		82
Other clinical supplies		23		23
Income provider to provider		34		34
Overperformance to Month 10	276			276
	276	698		972
HIV				
TB Masks		24		24
Consultant Staffing		10		10
Staff Grade Staffing		33		33
	0	67	0	67
Medicine				
Haematology	61			61
George Watts	7			7
Nell Gywnne MSSE	15			15
Edgar Horne MSSE	4			4
Endoscopy Out of Hours Cover –		66		66
Medicine - Band 7 Service Manager		48		48
Cardiology Consultant Recharge		32		32
AMU MSSE		22		22
	87	168	0	255
Surgery				
MSSE - historical budget pressure		151		151
MSSE increase in activity		14		14
MSSE increase in activity & historical budget pressure		217		217
MSSE leases		8		8
MSSE maintenance historical budget pressure		16		16
Prosthetics - historical budget pressure		112		112
Therapy Staff - decrease LOS initiative		56		56
Hire of special beds		5		5
Human Tissue Licence - new charge		8		8
Royal Marsden salary recharge - stopped		29		29
Decontamination supplies		12		12
Catering historical budget pressure		6		6
Lease cars - historical budget pressure		6		6
Linen - historical budget pressure		3		3
Linen - increase in activity additional theatre		4		4
Other clinical supplies - historical budget pressure		44		44
Patient appliances - historical budget pressure		30		30
Dressings - Mepitel -change in practice		80		80
Overperformance to Month 10	435			435
Plastics rota compliance costs			150	150
	435	801	150	1386

W&C				
Non-Midwifery staff increase to 4,600 deliveries.	360			360
John Florence (Ponsetti) SLA	41			41
Upgrading Ass Spec to Cons Post	17			17
Digital colposcopy service contract	5			5
Paed ENT SLA Increase in 07/08	35			35
Colposcopy Service		5		5
Breastfeeding Midwife (Quality/Baby Friendly)		48		48
Mental Health Midwife (NICE)		48		48
Paediatrics Admin and Clerical		100		100
Historic Underfunding AZ Theatre		117		117
Paediatrics Theatre budget underfunded		20		20
Paediatric OPD activity non pay costs		24		24
Costs transfered from Charity		200		200
Paediatric Capacity				
Paediatric Dental			312	312
Preop Assessment			82	82
Women's Medical Compliant Rota			173	173
Clinical Scientist			56	56
Obstetrics rota and cons cover funded from additional activity			0	0
	458	562	623	1643
Total Frontline Directorates	1256	2296	773	4323
Pharmacy				
Pharmacy IT Hardware maintenance	5			5
Increase in dispensary consumables	6			6
Technical service consumables	3			3
Re enforce pharmacy storage area	3			3
W&C Directorate support		24		24
W&C Directorate support - medicine management		19		19
	17	43	0	60
Therapies				
Paediatric Practitioners Additional Band 4 0.5wte	14			14
Inpatient Therapy team additional 20 hours band 6	12			12
	26	0	0	26
Total Clinical Support	43	43	0	86
Chief Executive				
Photocopier & rental Charges	5			5
Advisory Board membership	25			25
Corporate development			400	400
CLAHRC Bid			250	250
	30	0	650	680
Governance & Corporate Affairs				
FT Manager under funded	9			9
	9	0	0	9
Nursing				
Multi Faith Chaplain		7		7
Chaplain on Call		14		14
Voluntary Services Manager (AfC)		33		33
Clinical Learning Facilitator (AfC)		24		24
Skills and Devices training		41		41
		119		119
HR				
ESR Self Service Roll Out Project Implementer		45		45
Staff Bank Band 3 Pay Lift		20		20
Exit Interview Service		50		50
Childcare Post		3		3
Staff Survey	8			8
Bank staff software	3			3
	11	118	0	129

Finance				
Contribution London procurement Project		33		33
Zanzibar Licence		14		14
Clinical Coders premium		40		40
Agency Staff Q4 backlog		96		96
Agency Staff QI activity		16		16
Relocation of PP debtors		80		80
	0	279	0	279
Total Management Executive	50	516	650	1216
Estates				
Waste Disposal		20		20
Deep Cleaning		15		15
Security		28		28
Postage		20		20
Energy Contracts		100		100
	0	183	0	183
Private Patients				
Target Reduced Non Recurrently in 07-08	328			328
Credit Control/Debtors Agency Usage	76			76
	404	0	0	404
Central Budgets				
Pathology contract additional activity			180	180
Additional interest on new loans			300	300
Revenue cost of capital schemes			1404	1404
	0	0	1884	1884
Total Other Directorates	404	183	1884	2471
Total all Directorates	**1753**	**3038**	**3307**	**8096**

Members' Council Meeting, 8 May 2008

AGENDA ITEM NO.	2.2/May/08
PAPER	Staff Constituencies
AUTHOR	Julie Cooper, Foundation Trust Secretary
LEAD	Chris Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists the various options with regards the Foundation Trust staff constituencies in relation to the move to a Staff Opt system.
DECISION/ ACTION	The Members' Council is asked to discuss the proposed options with regards the staff constituencies and vote on which option to use going forward.

1. Introduction

The Members' Council voted unanimously for a move to an opt-out system for staff at the Members' Council meeting in November 2007. The Foundation Trust Secretary is in the process of making the necessary changes in support of this move. Subsequent to this, there has been a further suggestion to change the constitution with regards to the staff constituencies. The options in relation to this proposed change are outlined below. Once these changes are agreed by the Council, the amended constitution will need to be approved by Monitor.

2. Proposed change to the Staff Constituencies

As part of the process to implement the opt-out system for staff it was noted that the staff categories stipulated in the constitution do not directly correspond with those currently used by Human Resources. In addition, the lack of a candidate in the last election for the management constituency indicated that the membership of this constituency is poorly understood in terms of who should be in this category as many people are both clinical and serving in managerial role and it is small in comparison to the other categories.

The management constituency under the opt-out system will remain small with only 74 'non-clinical managers'. The exact numbers for each of the constituencies is noted below:

- Nursing and Midwifery 1047
- Medical and Dental 544
- Contracted ?
- AHP, Sci, Tech 361
- Support, A&C, Other 663
- Management(non clinical) 74

It had been suggested to merge the 'Management' constituency with 'Support, Admin and Clerical', but staff representatives on the Council felt strongly that any change should not lead to a decrease in the overall number of representatives.

As a result of reviewing other foundation trust constitutions, the following is proposed. The change in each option is highlighted. All options retain 6 seats.

Option 1
Have one staff constituency with six seats and no sub-categories. This would mean we move away from a system of vertical representation, with elected staff representing their own professional class, to one which is horizontal. Many trusts now follow this system including Basildon and Berkshire.

Option 2
Have six staff seats comprised of the following:
(1) Medical and dental practitioners staff class
(1) Nursing and midwifery staff class
(1) Allied health professionals: scientific and technical staff class
(3) All other staff

This system would mean administration, clerical and support staff, managerial staff and all contracted staff merge into one category with three seats.

This system is used by Bradford Teaching Hospital, Guys and Thomas's Hospital but they both only have four seats.

Option 3
Have six staff seats comprised of the following:
(2) nursing and midwifery staff class
(1) the medical practitioners class
(1) the clinical staff class
(2) the non-clinical staff class

This system is used by Yorkshire and Harrogate, but they only have four seats

Option 4
Have six staff seats comprised of the following:
(1) medical and dental staff class
(2) nursing and midwifery staff class
(1) allied health professionals: scientific and technical staff class
(1) contracted
(1) support, administration and clerical and all other staff

This option would mean we no longer have a staff constituency for management, but we add another seat to nursing and midwifery and thus maintain the overall number of staff seats. All managerial staff would then go into the support, admin and clerical group. Views were already expressed at the staff opt-out meeting that the administration constituency should not be merged with management as this might intimidate some members of staff from raising concerns.

Option 5
We keep the current system of having six staff seats comprised of the following:
(1) medical and dental staff class
(1) nursing and midwifery staff class
(1) allied health professionals: scientific and technical staff class
(1) contracted
(1) Support, administration and clerical
(1) management

Julie Cooper
Foundation Trust Secretary
May 2008

Members' Council Meeting, 8 May 2008

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LEAD	Chris Edwards, Chairman
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(1) contracted
(1) Support, administration and clerical
(1) management

Members' Council Meeting, 8th May 2008

AGENDA ITEM NO.	2.1/May/08
PAPER	Annual Plan 2008/09
AUTHOR	Amit Khutti, Director of Strategy and Service Performance
LEAD	Lorraine Bewes, Director of Finance and Information
SUMMARY	The membership and the Members' Council play a vital role in providing a community perspective to service development. The annual plan sets out a clear and shared vision amongst staff, members and external stakeholders of how the Trust and individual directorates will develop over the next 12 months. The purpose of this paper is to confirm to the Members' Council the corporate objectives and plans at directorate level and to give assurance that appropriate revenue and capital financial resources are budgeted for 2008/09 at Trust and directorate level. These figures and objectives will then be incorporated into the Annual Plan.
DECISION/ ACTION	The Council is asked to note the draft plan.

FINANCE AND CORPORATE PLAN 2008/09

1. Introduction

1.1 In previous meetings the Board has approved the Trust wide key corporate objectives, the principles and assumptions underpinning the budget setting for 2008/09 and approved the overall income and expenditure budgets, a corporate efficiency target of 4.4% and a plan to maintain a level 5 risk rating with Monitor. A separate paper was also tabled proposing principles and priorities for the Trust's capital investment strategy and programme.

1.2 These plans were subject to the completion of detailed business planning bilaterals with directorates which have now been concluded. The Board also asked for the capital programme to come back for final approval.

1.3 Therefore the purpose of this paper is to confirm to the Board the corporate objectives and plans at directorate level and to give assurance that appropriate revenue and capital financial resources are budgeted for 2008/09 at Trust and directorate level.

2. Corporate Objectives

2.1 The Trust has consulted with the Members Council on the key corporate objectives for 2008/09 and agreed them. The Board will recall that there are five key themes:

1. Focus on patient safety and quality
2. Deliver effective and efficient pathways of care
3. Be the provider of choice
4. Deliver excellence in teaching and research
5. Create robust infrastructure for the future

2.2 The associated deliverables for 2008/09 are:

1. Focus on patient safety and quality
    a. Achieve consistent improvement as benchmarked through best practice
    b. Deliver target reductions in healthcare acquired infections
    c. Maintain CNST level 2 and make progress towards CNST level 3
2. Deliver effective and efficient pathways of care
    a. Deliver the 18 weeks target in full by December 08 then sustain performance and identify areas where we can go further
    b. Work in partnership with PCTs to deliver recommendations from the consultation on Healthcare for London: A Framework for Action
    c. Introduce case-management of patients
    d. Achieve key financial targets
3. Be the provider of choice
    a. Improve patient satisfaction
    b. Redefine and develop the 'Chelsea & Westminster Offer' to staff
    c. Secure a larger patient base for the Trust in collaboration with PCTs and other providers

4. Deliver excellence in teaching and research
    a. Deliver excellence in teaching
    b. Implement the research strategy
    c. Lead a Collaboration for Leadership in Applied Health Research and Care
5. Create robust infrastructure for the future
    a. Provide excellent administrative processes for elective patient pathways
    b. Ensure services have strong clinical leadership and managerial and corporate support to enable increased devolution of responsibility to front line services
    c. Maintain robust governance and assurance processes
    d. Agree and approve a migration path from Lastword to an alternate system

2.3 The Board has already seen the draft overall corporate plan. The Executive has now met with all directorates and agreed draft corporate objectives in line with the 5 overarching themes. The key highlights are set out in the following section. The full corporate plan with directorate business plans as appendices will be circulated before the May Board meeting and this will include in addition to this paper:

1. Review of 2007/08
2. Summary of Objectives and Business Plans for developments
3. Risk assessment.

2.4 As an FT the Trust is required to sign off its corporate plan with a 3 year financial plan with Monitor by the 30th May and this is scheduled for approval at the May Board.

2.5. The key objectives in the directorate business plans are as follows:

2.6. Anaesthetics and Imaging Directorate

- Improve theatre and Treatment Centre productivity and efficiency.
- Support the creation of the joint female surgical ward.
- Undertake marketing of appropriate services for example TSSU.
- Improve procurement across all theatres to realise savings and economies of scale.
- Develop the Hand Management Service.
- Develop a Balloon Kyphoplasty service in Imaging.
- Introduce a dedicated cardiac nuclear medicine (MPI) service.
- Ensure ITU is as responsive and efficient as possible.

2.7 HIV and GUM Directorate

- Continue to improve access for hard to reach groups, reduce levels of sexually transmitted infection and increase early diagnosis of HIV.
- Relocate Victoria Clinic to new premises in Soho.
- Enhance out patient, inpatient and day care services for HIV positive care.
- Ensure that 18WW target is met and data is complete and robust.
- Continue to achieve GUM 48-Hour Access target (100% offered) and reduce the gap between offered and seen (95%).
- Expand sexual health services' market share by achieving GUM growth of 10% and HIV growth of 13%.
- Maximise and support our teaching/academic/clinical research opportunities with our partners.
- Replace GUS.
- Continue to enhance call centre service.
- Improve accuracy and timeliness of clinical coding and activity data recording, reporting and quality.
- Continue to provide an excellent specimen reception centre and laboratory service to the directorate (HIV) and SSAT to support research and exploit opportunities for income generation.

2.8 Medicine Directorate

- Develop and secure an inpatient Sleep Studies service.
- Further develop outpatient/community models of care to reduce unnecessary hospital appointments and stays.
- To improve the prevention of stroke/TIA through timely detection and effective management of patients at risk by managing risk factors in line with clinical guidelines.
- To achieve 95% on 12 Performance Indicators for National Sentinel Audit for Stroke 2008.
- To meet the internal and external Neurophysiology target for 4 and 6 weeks.
- Ensure that the Directorate meets and maintains its statutory obligation under EWTD for doctors in training.
- To continue the redesign of the Cardiology ECG Outpatient service to improve efficiency and maximise patient care.
- Undertake review of the Dermatology service.
- Deliver and maintain the 18 week wait target throughout 2008/09 through patient flow and pathway redesign for elective patients.

- To improve the pathway for acute medical patients by streamlining admission through A&E and AMU; making the transfer of consultant care explicit and timely; and explore the options available to expedite delayed discharges into the community.

2.9 Surgery Directorate

- Deliver and maintain the 18 week wait target throughout 2008/09 through patient flow and pathway redesign for elective patients.

- Fully roll out Service Line Reporting to ensure all income is captured and utilise to expand services and improve efficiency.

- Develop the emergency surgery pathway, focusing on providing prompt, safe and timely care and reducing the emergency length of stay and unnecessary theatre delays.

- To review the process of elective admissions in order to streamline the patient pathway.

- Ensure that the Directorate meets and maintains its statutory obligation under EWTD for doctors in training.

- Develop the role of nursing staff to increase skills and flexibility and reduce the reliance on bank and agency staff.

- Develop and expand specialist services.

- Support the creation of the joint female surgical ward with gynaecology.

2.10 Women and Children's Directorate

- Achieve EWTD targets on medical rotas.

- Develop Service Line Reporting.

- Develop and implement Maternity Service Action Plan.

- Achieve 60 hour cover for Maternity.

- Implement Private Maternity expansion.

- Develop bid for Specialist Paediatrics in North West London.

- Develop and implement permanent infrastructure to support 18 weeks delivery for Paediatrics.

- Develop and implement permanent infrastructure to support 18 weeks delivery for Gynaecology.

- Implement permanent infrastructure in NICU to support activity levels and PMU expansion.

- Support the creation of the joint surgical ward with surgery.

- Undertake marketing of appropriate services for example TSSU.

2.11 Support Services Directorate

Estates and Facilities

- Strengthen the Health and Safety agenda within the Trust, ensuring that robust governance arrangements are in place to safeguard the wellbeing of patients, staff and hospital visitors.

- Refine the Estates Strategy to ensure that it underpins future clinical activity projections, including the potential paediatric rationalisation and increasing single room provision.

Pharmacy

- Reduce outpatient waiting times for prescriptions.

- Deliver effective and efficient pathways of care for inpatient prescribing.

Therapies

- Support front line directorates with the implementation of new therapy services such as the pulmonary rehabilitation service.

2.12 Corporate Directorates

CEO

- To work with the Members' Council to ensure that their views are taken into account in setting the Trust's strategic direction and to continue to build the Trust's membership.

Nursing

- Implement the Saving Lives Care Bundles to help reduce infection rates and achieve the C.difficile and MRSA stretch targets.

- Undertake a programme of real time patient surveys.

HR

- Achieve compliance with the August 2009 EWTD for all doctors in training.

- Focus on increasing employee engagement to encourage the development of a workforce of inspired employees willing to contribute additional discretionary effort.

Finance

- Develop the provision and use of service line reporting and develop monthly service line reports.

- Prepare for the adoption of IFRS accounting from 2009/10.

- Improve the effectiveness and responsiveness of information provision to the Trust, especially the development of regular update of capacity plan (quarterly) and the provision of 18 week real time PTLs and referrals tracking.

- Achieve 100% coding within 7 days and improve the accuracy of coding measured by regular audit.

IM&T

- Maintain the Electronic Patient Record Services systems and software until an alternative set of systems can be implemented particularly LastWord, GUS and CMIS Maternity. Replace end of life software suppliers by adopting escrow and maintaining both hardware and software.

- Provide 24/7 system and service support to the Trust and outlying sites.

3. Final Revenue Plan for 2008/09

Following completion of the directorate bilaterals the detailed revenue and capital plans have been further assessed. The Executive has reviewed proposed developments and efficiency savings and can give the Board assurance that these plans support delivery of the key government target areas such as infection control, patient experience surveys and access targets, key Trust developments and support achievement of full EWTD compliance for 2008 including an increase from 40 to 60 hours obstetric cover in labour wards.

Since the last report we have finalised directorate cost pressures and developments, completed a review of the reserve commitments to be carried forward and have released £7.4m towards new year cost pressures and developments. As a result we have reviewed the efficiency requirement down, which is dealt with in the next section.

The revenue plan is summarised in Table 1 below, which includes a comparison with the high level plan reported last month, to highlight the key changes.

Appendix 1 sets out the starting approved budgets of £257.776m by directorate.

Appendix 2 details the build up of the income plan of £265.748m

Appendix 3 details the cost pressures and developments funded and reserved, viz

	£m
2007/08 cost pressures	1.753
2008/09 cost pressures/developments	6.345
2008/09 general reserve	2.272

High Level Resource and Expenditure Assumptions **Table 1**

	Last Report	Final	Change
	£000	£000	£000
Income Forecast 2008/09 net of Efficiency Saving	265,748	265,748	0
less Target Surplus for 2008/09 to retain 5 star rating	7,972	7,972	0
Resources available	257,776	257,776	0
Expenditure Forecast			
Current rollover expenditure budgets 2008/09	236,290	228,934	7,356
Depreciation 2008/09	8,026	9,065	-1,039
PDC Dividend 2008/09	8,687	8,687	0
Net Interest Receivable 2008/09	-1,000	-1,000	0
2007/08 Cost Pressures	2,630	1,753	877
Rollover Expenditure Requirements	**254,633**	**247,439**	**7,194**
Central Reserves for 2008/09			
Generic Inflation			
Pay	3,890	3,890	0
Drugs check inflation requirement	1,028	1,028	0
Other Non Pay	1,642	1,350	292
New High Cost Drugs	1,800	1,800	0
Baseline Expenditure 2008/09	**262,993**	**255,507**	**7,486**
Less Savings target	-8,217	- 6,348	-1,869
Baseline Budget (see Starting Budgets)			
2008/09 Cost Pressures and Developments			
Cost Pressures and Developments	3,000	6,345	-3,345
Reserve for Income loss/Contingency		2,272	-2,272
Current Budget Approvals	**257,776**	**257,776**	**-**

4. Efficiency Targets

4.1 Directorates were asked to prepare their Business Plans for 2008/09 with an indicative target of 4.5% for efficiency savings.

4.2 As a result of the release of reserves towards new year cost pressures and developments, the CIP requirement could be reduced from £8.217m (4.4%) to £5.223m (2.8%). However, the Board will recall from last year's strategic plan and risk assessment, that there is a potential threat to income levies for SIFT and MFF over the next 3 years. Whilst there are no concrete proposals that we can model, given the potential size of the impact, it would be prudent to begin to make provision against this possible loss while we can.

4.3 The SIFT income budget for 08/09 is £13m (including £1.1m invoiced to Imperial College Healthcare Trust for pathology teaching) for 155 FTEs, i.e. £84k per FTE. The national average is £35k per FTD and it is likely that the DH will redistribute this funding in line with the average. Therefore a worst case scenario could see a drop in income of c£7m. It is likely that this would be phased over a number of years but it would be prudent to assume a 20% reduction in 2009/10 i.e. £1.5m.

4.4 The MFF levy is budgeted at £42.3m and reflects an uplift of 40.2% on tariff based income to compensate us for the geographical costs of living in London. There has been constant pressure to review the MFF, particularly in the light of the agreement of a new national pay contract, Agenda for Change. Several years ago the levy was reviewed resulting in a capped 2% fall in the MFF levy. If this were to be repeated this would present a potential loss of £0.84m. We are aware that the DH is reviewing the MFF levy with potential impact in 2009/10.

4.5 Based on the above, it is proposed to maintain the CIP requirement at 3.5% to start to build up reserves against these income losses. A 3.5% CIP target delivers the level 5 financial risk rating and a general reserve of £2.2m.

4.6 Table 2 shows the progress with identifying cost improvement initiatives to date together with the risk assessment. Details of the schemes are available on request. In summary, 95% of schemes have been identified against the overall savings requirement of £6.348m. Any schemes identified in excess of a directorate's in year requirement will be credited towards their next year target.

Risk Assessment of Identified Savings **TABLE 2**

Directorate	Efficiency target		High	Medium	Low	Total
	Original	Proposed 3.5%				
Fac & Ops	755,000	597,000		479,000		479,000
Medicine & A&E	1,398,000	921,000	42,000	273,000	329,000	644,000
HIV/GUM	1,854,000	381,000			589,209	589,209
Imaging & Anaesthetics	1,191,000	866,000	405,900	135,698	153,849	695,447
Surgery	860,000	618,000	195,000	525,000	75,000	795,000
Women and Children	1,587,000	1,190,000	395,000	326,000	475,000	1,196,000
Pharmacy	170,000	136,000			115,452	115,452
Therapies	0	169,000	113,000	78,000	65,000	256,000
Man Exec	401,000	470,000		250,000		250,000
Corporate	0	1,000,000		1,000,000		1,000,000
	8,216,000	**6,348,000**	**1,150,900**	**3,066,698**	**1,802,510**	**6,020,108**
						95%

5. Capital Plan

6.1 The Board received a paper at the last meeting setting out the principles and priorities for the Trust's capital investment strategy. It explained the available sources of finance for capital investment for 2008/09 and proposed an initial capital programme. The proposals have been updated in the light of directorate bilaterals and the final outturn for 2007/08 and the strategy, principles and programme are represented for approval. The detailed scheme analysis is available on request.

6.2 Capital Investment Strategy

The capital investment strategy needs to support the Trust's strategic development objectives by ensuring that:

a) The asset base is kept up to date and replaced as useful lives are reached in order to avoid technical obsolescence and minimise risks, especially those highlighted on the Trust's risk register;

b) The asset base is aligned to deliver the Trust's planned developments arising from its corporate objectives.

6.3 Therefore the priorities for capital investment in 2008/09 will be to:

a) Fund prior commitments for capital projects commenced in prior years;

b) Fund assets that are essential to ensure clinical safety, especially to address items highlighted on the risk register, after all possible alternatives have been considered. This may include replacement of out-of-life equipment;

c) Maintain and enhance the fabric of the building;

d) Fund assets to facilitate strategic service developments;

e) Fund assets that are essential to deliver key performance targets, and productivity/efficiency benchmarks are already within the upper quartile and all possible alternatives have been considered;

f) Fund 'invest to save' initiatives, with clear evidence that savings will be made;

g) Fund assets essential for growing a service, where there is clear evidence of increased demand and it is clear that the contribution the service makes to the Trust will increase sufficiently to offset the effect of the initial investment.

h) Fund assets to address key identified risks.

6.4 As part of the Business Planning process, budget holders have been asked to submit their capital bids in line with the priorities above.

6.5 Sources of capital funding

6.6 The sources of funding for capital investment in 2008/09 are set out in detail in Table 3 below. The Board will note that we have built up significant resources for the future strategic development of the Trust and it is regarded as prudent to make full use of our existing borrowing capability in order to maximise development funds for the Trust.

6.7 Table 3 shows that the maximum available resources for the capital programme are £54.2m, subject to finalising the outturn for 07/08. The proposal is to utilise the internal resources available of £39.9m first and to apply for a further loan from the Foundation Trust Financing Facility if further funds are required, in the event that the paediatric tertiary centre bid is agreed (See 6.10 and 6.11 below).

TABLE 3

FUNDING SOURCES FOR CAPITAL INVESTMENT

	@ 3rd April 08 FY 08-09 £000	**FINAL FY 08-09 £000**
Surplus cash for capital b/fwd	2,813	11,250
Depreciation	8,590	9,065
Income & Expenditure reserves b/fwd 31.03.07	5,030	5,030
Forecast Net Surplus to 31.03.08	12,142	14,625
Internal resources available for capital programme	**28,575**	**39,970**
Prudential Borrowing Limit Maximum Borrowings	14,275	14,275
Maximum resources available for capital programme	**42,850**	**54,245**
Proposed Capital Expenditure	**(19,839)**	**(28,465)**
Surplus cash for capital c/fwd	**23,011**	**25,780**

6.8 The sources available for funding capital investment have increased by £11.4m from the last report due to slippage on the 2007/08 programme (but this is matched by increased commitments in 2008/09), increase in depreciation and an improvement of £2m in the final net surplus position.

6.9 The Board is reminded that as part of the Trust's authorisation as a Foundation Trust in October 2006, the Trust took out a £12.5m loan from the Foundation Trust Financing Facility to fund part of the Trust's capital programme in 2006/07 and 2007/08. All of this finance facility was utilised by 31st March 2008. Therefore the Trust's accumulated reserves from prior to 1st April 2007 are available in 2008/09 for capital investment. The Public Dividend Capital received in 2007/08 was to part fund the PACS system which was implemented last year.

6.10 The Trust will be making a submission to the NW London Commissioners this summer in respect of centralising tertiary paediatrics and if we are successful, we would need to be in a position to proceed in the autumn to develop significant additional paediatric facilities. It is estimated that we would need c£25m for stage 1 of the development.

6.11 It is therefore proposed that the Board approves an initial capital programme budget to proceed with must do building works, equipment and IT and approved business cases and develop business cases for further capital bids to hold for appraisal in the autumn in the context of strategic decisions on the siting of the tertiary paediatrics centre.

6.12 The Board should note that the Trust does not index its asset base each year as it did as an NHS Trust but is required to carry out an independent valuation at least every 3 years. The last asset valuation was carried out on 1st April 2006 and the next valuation will be on 1st April 2009, impacting on accounts for 2009/10. Therefore part of the surplus in 2007/08 and 2008/09 will derive from the fact that prices have been uplifted for indexation but will not impact on the asset base until 2009/10. This will be planned for in our 3 year forward plan. Therefore within the retained surplus for 2007/08 of £14.1m approximately £1.5m is non-recurrent and potentially £1.9m of our planned surplus for 2008/09 of £8m is also non-recurrent.

4. Final Capital Programme

7.1 Through the Business Planning process, bids totalling £33.6m have been received. The Capital Programme Board has reviewed these bids against the corporate planning objectives and the priorities listed in section 6.2 and 6.3.

7.2 The Capital Programme Board has considered capital requirements arising from extant risks on the risk register and is satisfied that provision has been made in the proposed capital programme to address these.

7.3 The Capital Programme Board has also considered the 5 year backlog maintenance schedule to maintain the site at Condition B status. As at the beginning of 2008/09, approximately £3.8m is required in 2008/09 to reduce backlog maintenance and all of this has been provided for in the programme. This leaves a further £6.9m to be addressed over the next 4 years.

7.4 The Capital Programme Board proposes for approval an initial capital programme budget of £28.464m to proceed with must do building works, equipment and IT and approved business cases, leaving scope for financing the paediatrics tertiary centre if approved this summer. A summary is set out in Table 4 below:

Capital Programme 2008/09 **Table 4**

	Total Capital Bids & Carry forward Presented	**Total Bids Recommended for Approval**
Building Projects	12,597,000	12,417,000
Building Projects - Awaiting Business Case	7,847,220	5,807,220
Equipment	6,875,476	5,965,925
IT	5,798,500	3,774,500
Contingency	500,000	500,000
Total Capital Programme	**33,618,196**	**28,464,645**

7.5 The split between c/fwd commitments from 2007/08 and new developments for 2008/09 is set out in Table 5.

Capital Programme 2008/09 **Table 5**

	C/Fwd commitments 2007/08	New Bids 2008/09
Building Projects	6,625,000	5,792,000
Building Projects - Awaiting Business Case	-	5,807,220
Equipment	3,465,925	2,500,000
IT	465,500	3,309,000
Contingency	-	500,000
Total Capital Programme	**10,556,425**	**17,908,220**

5. CONCLUSIONS AND RECOMMENDATIONS

The Board is asked to:

a) Note and approve the Directorate corporate objectives.
b) Approve the final revenue plan, noting the reduced corporate efficiency target of 3.5%, reserved developments and provision for future income loss.
c) Approve the capital investment strategy and capital programme of £28.5m outlined in the paper and delegate budget approval and progress monitoring to the Capital Programme Board.
d) To note that this leaves c£25m unutilised funds from internally generated sources and financing, which will be further appraised in the autumn following decisions on the tertiary centre for paediatrics.

Lorraine Bewes
Director of Finance and Information
23.04.08

Starting budgets 2008/09 **APPENDIX 1**

Directorates	Pay £000's	Non Pay	Sub Total	2007/08 Cost Pressures	Sub Total	Cost Pressures	Total	Efficiency Savings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
A&I	21,551	4,999	26,550	276	26,826	698	27,524	(866)	26,658
HIV	12,020	30,297	42,317		42,317	67	42,384	(381)	42,003
Medicine	24,557	7,979	32,536	87	32,623	168	32,791	(921)	31,870
Surgery	15,013	4,335	19,348	435	19,783	801	20,584	(618)	19,966
W&C	33,225	4,634	37,859	458	38,317	562	38,879	(1,190)	37,689
Pharmacy	4,329	319	4,648	17	4,665	43	4,708	(136)	4,572
Therapies/Dietetics	4,827	159	4,986	26	5,012		5,012	(169)	4,843
Chief Exec	1,024	167	1,192	30	1,222		1,222		1,222
Governance	822	3,280	4,103	9	4,112		4,112		4,112
Nursing	2,447	187	2,634		2,634	119	2,753	(54)	2,699
Human Resources	1,553	185	1,739	11	1,750	118	1,868		1,868
Finance	3,965	828	4,793		4,793	279	5,072	(258)	4,814
Information Tech	2,296	2,262	4,559		4,559		4,559	(159)	4,400
Occupational Health	373	58	430		430		430		430
Facilities	249	17,612	17,861		17,861	183	18,044	(568)	17,476
Operations	1,081	7	1,088		1,088		1,088	(28)	1,060
Adult PP	1,003	484	1,487	404	1,891		1,891		1,891
Overseas Patients	36		36		36		36		36
ACU	794	440	1,234		1,234		1,234		1,234
PGME	312	103	415		415		415		415
Projects	879	70	948		948		948		948
Sim Centre / Clinical Skills	447	66	513		513		513		513
SLAs		14552	14,552		14,552		14,552		14,552
Reserves		3,108	3,108		3,108		3,108		3,108
Total Directorates	132,801	96,132	228,934	1,753	230,687	3,038	233,725	(5,348)	228,377
Central budgets									0
Depreciation		9,065	9,065		9,065	1,404	10,469		10,469
PDC Dividend		8,687	8,687		8,687		8,687		8,687
Net interest receivable		(1,000)	(1,000)		(1,000)		(1,000)		(1,000)
Reserves & Provisions							0		0
High Cost Drugs		1,800	1,800		1,800		1,800		1,800
Generic Inflation	3,890	2,378	6,268		6,268		6,268		6,268
Other developments						1,903	1,903		1,903
General Contingency						2,272	2,272		2,272
Corporate Efficiencies								(1,000)	(1,000)
	136,691	117,062	253,754	1,753	255,507	8,617	264,124	(6,348)	257,776

Analysis of Income Plan

Appendix 2

Description	Total Budget 07-08	Forecast Outturn 2007/08 as at M10	Forecast 2008/09	Change from out-turn
	£	£	£	£
SLA Contracts with PCTs	(121,590,556)	(121,590,556)	(124,676,213)	3,085,657
NEL Threshold Impact			593,000	
GUM				
Pct Over Performance	(3,182,552)	(4,972,417)	0	(4,972,417)
Pct Under Performance	1,933,591	4,817,082	0	4,817,082
HIV	(43,105,902)	(43,639,284)	(45,316,899)	1,677,615
HIV Overperformance	(1,214,015)	(476,485)	0	(476,485)
Nicu Consortium Income	(4,596,978)	(4,173,512)	(4,722,140)	548,628
Burns Consortium	(2,358,223)	(2,137,104)	(2,081,346)	(55,758)
High Cost Drugs	68	11,635	(1,804,602)	1,816,237
2003-2004 Deficit Payback	(2,204,000)	(2,204,000)		(2,204,000)
Prior Year Balances	0	35,322		35,322
Subtotal Contract Income	**(176,318,567)**	**(174,329,320)**	**(178,008,200)**	**4,271,880**
Non Contract Activity & Over Seas	(2,382,777)	(2,189,975)	(2,776,726)	586,751
NHS Prescription Income	(93,831)	(124,325)	(127,184)	2,859
Road Traffic Accident Income	(347,700)	(377,701)	(386,388)	8,687
Non DoH Overseas Visitors	(753,480)	(791,310)	(809,000)	17,690
Provider To Provider Diagnosti	(112,337)	(186,030)	(190,000)	3,970
Provider To Provider Sla- Brom	(235,553)	(235,548)	(241,000)	5,452
Provider To Provider SLA Clini	(150,818)	(157,740)	(161,000)	3,260
AHP Services	(49,055)	(67,368)	(69,000)	1,632
Provider To Provider ITU/HDU services	0	(17,684)	(18,000)	316
SLA Work in Progress	0	(116,219)	(119,000)	2,781
Cost Per Case	(102,156)	(115,306)	(118,000)	2,694
Other Income	(1,650,894)	(296,273)	(336,499)	40,226
HIV Drugs		(1,058,101)	(1,058,101)	0
HIV research		(213,000)	(213,000)	0
Salary recharges- Kobler staff		(165,400)	(165,400)	
Market Forces Factor	(39,621,002)	(41,796,144)	(42,307,000)	510,856
Pbr Clawback	6,428,000	6,428,000		6,428,000
Subtotal Other Clinical Income Including MFF	**(39,071,603)**	**(41,480,125)**	**(49,095,299)**	**7,028,423**
Occupational Health Service -	(133,415)	(110,752)	(113,300)	2,547
Distinction Awards	(864,948)	(864,940)	(877,922)	12,982
Income From Training Sessions	(329,894)	(284,949)	(291,503)	6,554
Income From Sponsors	(334,237)	(629,988)	(334,237)	(295,751)
Income From Catering Services	(427,368)	(440,820)	(450,959)	10,139
Income From Patients Hotel	(6,648)	(1,416)	(1,416)	0
Income From Car Parking Fees	(245,784)	(401,735)	(401,735)	0
Income From Rooftop Aerials	(7,188)	(1,558)	(1,594)	36
Income From Cash Service Till	(9,412)	(13,043)	(13,343)	300
Income From Room Hire	(9,228)	(15,803)	(16,166)	363
Income From Purchasing Arrange	(48,075)	(98,861)	(49,181)	(49,681)
Donated Depreciation Income	(260,004)	(308,577)	(260,004)	(48,573)
Miscellaneous Non Nhs Income	(400,674)	(757,055)	(419,506)	(337,550)
Clinical Trials Income	(49,080)	(78,588)	(49,080)	(29,508)
Grant	(6,000)	(12,000)	(6,000)	(6,000)
Income From Medical Records	(30,760)	(27,795)	(28,435)	639
Private Therapy Services	(32,040)	(16,963)	(17,353)	390
Charitable Funds Income	(78,832)	(127,528)	(78,832)	(48,696)
Provision Of Payroll Service	(241,482)	(292,555)	(179,440)	(113,115)
Critical Care Network Planning	(211,350)	(211,350)	(216,211)	4,861
Tissue Viability	(37,500)	(49,091)	(38,363)	(10,728)
Transplant Co-Ordinators	(659,657)	(718,828)	(735,361)	16,533
Provider Sift Income	4,980	0		0
Facilities Recharges	(1,453,809)	(1,640,675)	(1,487,247)	(153,428)
Pharmacy Services	(496,360)	(496,360)	(507,776)	11,416
Provider Sift Income	(12,624,480)	(12,809,466)	(12,965,341)	155,875
Provider Madel Pensions	(600,800)	0		0
R&D Specialist Projects	(2,891,566)	(2,891,569)	(1,703,909)	(1,187,660)
Nmet Income	(630,912)	(632,306)	(646,685)	14,378
Madel - Split Funding	(6,887,491)	(7,140,428)	(6,990,803)	(149,625)
Madel - Flexible Trainees	(318,724)	(354,483)	(323,505)	(30,978)
Madel - Pgme	(651,286)	(655,028)	(667,568)	12,540
CLARHIC Bid		0	(245,000)	245,000
Salary Recharge - Medical	(2,267,846)	(1,519,635)	(1,562,185)	42,550
Salary Recharge - Non Medical	(757,538)	(878,146)	(778,749)	(99,397)
Grand Total Other Non Clinical Income	**(33,999,408)**	**(34,482,293)**	**(32,458,707)**	**(2,023,586)**
Prescription Income	(56,557)	(179,205)	(187,628)	8,423
Self Funded Acu Income	(1,085,767)	(1,254,895)	(1,313,875)	58,980
Private Maternity Transfer			1,000,000	
Private Inpatient Services	(6,093,838)	(4,991,772)	(5,226,385)	234,613
Private Outpatient Services	(330,472)	(437,815)	(458,392)	20,577
Grand Total Private Patient Income	**(7,566,634)**	**(6,863,687)**	**(6,186,280)**	**322,593**
			0	0
Total All Income	**(256,956,212)**	**(257,155,425)**	**(265,748,486)**	**9,599,310**

Cost Pressures Approved at Bi- Laterals

APPENDIX 3

	Approved Phase 1	Bi-lateral Meetings		Total Approved
		Approved funding	Reserved	
Frontline Directorates				
A&I				
MSSE - historical budget pressure		96		96
MSSE increase in activity		173		173
MSSE leases		58		58
MSSE maintenance		16		16
Prosthetics - historical budget pressure		13		13
Increase in activity/historical budget pressure		43		43
catering historical budget pressure		35		35
Laboratory equipment/materials		17		17
Increase in activity due to opening additional theatre		53		53
Increase in laundry activity by ISS/infection control		39		39
Stationery - historical budget pressure		12		12
Hire of special beds		4		4
Anaesthetic Practitioner - charities to share funding @ 50%		82		82
Other clinical supplies		23		23
Income provider to provider		34		34
Overperformance to Month 10	276			276
	276	698		972
HIV				
TB Masks		24		24
Consultant Staffing		10		10
Staff Grade Staffing		33		33
	0	67	0	67
Medicine				
Haematology	61			61
George Watts	7			7
Nell Gywnne MSSE	15			15
Edgar Horne MSSE	4			4
Endoscopy Out of Hours Cover –		66		66
Medicine - Band 7 Service Manager		48		48
Cardiology Consultant Recharge		32		32
AMU MSSE		22		22
	87	168	0	255
Surgery				
MSSE - historical budget pressure		151		151
MSSE increase in activity		14		14
MSSE increase in activity & historical budget pressure		217		217
MSSE leases		8		8
MSSE maintenance historical budget pressure		16		16
Prosthetics - historical budget pressure		112		112
Therapy Staff - decrease LOS initiative		56		56
Hire of special beds		5		5
Human Tissue Licence - new charge		8		8
Royal Marsden salary recharge - stopped		29		29
Decontamination supplies		12		12
Catering historical budget pressure		6		6
Lease cars - historical budget pressure		6		6
Linen - historical budget pressure		3		3
Linen - increase in activity additional theatre		4		4
Other clinical supplies - historical budget pressure		44		44
Patient appliances - historical budget pressure		30		30
Dressings - Mepitel -change in practice		80		80
Overperformance to Month 10	435			435
Plastics rota compliance costs			150	150
	435	801	150	1386

W&C				
Non-Midwifery staff increase to 4,600 deliveries.	360			360
John Florence (Ponsetti) SLA	41			41
Upgrading Ass Spec to Cons Post	17			17
Digital colposcopy service contract	5			5
Paed ENT SLA Increase in 07/08	35			35
Colposcopy Service		5		5
Breastfeeding Midwife (Quality/Baby Friendly)		48		48
Mental Health Midwife (NICE)		48		48
Paediatrics Admin and Clerical		100		100
Historic Underfunding AZ Theatre		117		117
Paediatrics Theatre budget underfunded		20		20
Paediatric OPD activity non pay costs		24		24
Costs transfered from Charity		200		200
Paediatric Capacity				
Paediatric Dental			312	312
Preop Assessment			82	82
Women's Medical Compliant Rota			173	173
Clinical Scientist			56	56
Obstetrics rota and cons cover funded from additional activity			0	0
	458	562	623	1643
Total Frontline Directorates	1256	2296	773	4323
Pharmacy				
Pharmacy IT Hardware maintenance	5			5
Increase in dispensary consumables	6			6
Technical service consumables	3			3
Re enforce pharmacy storage area	3			3
W&C Directorate support		24		24
W&C Directorate support - medicine management		19		19
	17	43	0	60
Therapies				
Paediatric Practitioners Additional Band 4 0.5wte	14			14
Inpatient Therapy team additional 20 hours band 6	12			12
	26	0	0	26
Total Clinical Support	43	43	0	86
Chief Executive				
Photocopier & rental Charges	5			5
Advisory Board membership	25			25
Corporate development			400	400
CLAHRC Bid			250	250
	30	0	650	680
Governance & Corporate Affairs				
FT Manager under funded	9			9
	9	0	0	9
Nursing				
Multi Faith Chaplain		7		7
Chaplain on Call		14		14
Voluntary Services Manager (AfC)		33		33
Clinical Learning Facilitator (AfC)		24		24
Skills and Devices training		41		41
		119		119
HR				
ESR Self Service Roll Out Project Implementer		45		45
Staff Bank Band 3 Pay Lift		20		20
Exit Interview Service		50		50
Childcare Post		3		3
Staff Survey	8			8
Bank staff software	3			3
	11	118	0	129

Finance				
Contribution London procurement Project		33		33
Zanzibar Licence		14		14
Clinical Coders premium		40		40
Agency Staff Q4 backlog		96		96
Agency Staff QI activity		16		16
Relocation of PP debtors		80		80
	0	279	0	279
Total Management Executive	50	516	650	1216
Estates				
Waste Disposal		20		20
Deep Cleaning		15		15
Security		28		28
Postage		20		20
Energy Contracts		100		100
	0	183	0	183
Private Patients				
Target Reduced Non Recurrently in 07-08	328			328
Credit Control/Debtors Agency Usage	76			76
	404	0	0	404
Central Budgets				
Pathology contract additional activity			180	180
Additional interest on new loans			300	300
Revenue cost of capital schemes			1404	1404
	0	0	1884	1884
Total Other Directorates	404	183	1884	2471
Total all Directorates	**1753**	**3038**	**3307**	**8096**

Members' Council Meeting, 8th May 2008

AGENDA ITEM NO.	2.1/May/08
PAPER	Annual Plan 2008/09
AUTHOR	Amit Khutti, Director of Strategy and Service Performance
LEAD	Lorraine Bewes, Director of Finance and Information
SUMMARY	The membership and the Members' Council play a vital role in providing a community perspective to service development. The annual plan sets out a clear and shared vision amongst staff, members and external stakeholders of how the Trust and individual directorates will develop over the next 12 months. The purpose of this paper is to confirm to the Members' Council the corporate objectives and plans at directorate level and to give assurance that appropriate revenue and capital financial resources are budgeted for 2008/09 at Trust and directorate level. These figures and objectives will then be incorporated into the Annual Plan.
DECISION/ ACTION	The Council is asked to note the draft plan.

Approach to Annual Planning for 2008/09

Purpose of annual planning
The annual service planning process and resulting products should fulfil several functions:

1. Set out a clear and shared vision amongst staff, Members and external stakeholders of how the Trust and individual directorates will develop over the next 12 months;
2. Set out how the Trust will deliver both excellent service quality and excellent use of resources by identifying key corporate aims and objectives, targets, planned activity and new developments and how resources will be deployed to achieve these;
3. Ensure bottom-up directorate plans are aligned with corporate aims, values, objectives and targets;
4. Capture both top-down and bottom-up plans in an overall annual plan which will serve as a basis for ongoing in-year reviews between the Executive Team and individual directorates;
5. Allows the Executive Team to provide assurance to the Board, to Monitor (the regulator of Foundation Trusts) and to the Membership Council on planning for 2008/09 and on performance against plan.

Trust approach to annual planning

We intend to build on the strengths of last year's approach to annual planning which involved significant consultation with staff and which incorporated feedback from the Members Council.

Although the details of our approach are being agreed, the broad outline will be as follows:

- The Board and senior managers will discuss the key strategic issues facing the Trust and agree key corporate aims and objectives;
- Closer engagement with Kensington & Chelsea PCT as our Lead Commissioner to ensure we have a shared understanding of the health needs and demand for acute services of our patient population;
- Directorates will develop their own plans through widespread consultation with staff. Directorate plans must take forward corporate aims and objectives, as well as developing local initiatives in alignment with the corporate aims;
- Financial and activity planning will start earlier than last year, with key assumptions and approach circulated and agreed with the directorates;
- Directorate plans will be challenged and agreed through a series of bilateral meetings with the Trust Executive team.

How would the Members Council like to get involved in annual planning for 2008/09?

We would like to understand how the Council would like to be involved in this year's annual planning cycle, and have outlined different options below.

According to the Trust constitution, one of the Members Council's roles and responsibilities is to:

> "to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Foundation Trust's forward planning;" (7.3.1.2.)

Last year the Members Council was invited to attend workshops led by the Deputy Chief Executive and the Director of Finance and Information, to comment in particular on the Trust's draft Corporate Objectives. Valuable feedback was received from these workshops and the Objectives were refined accordingly (last year's final Corporate Objectives are attached in Appendix 1 for information).

In terms of the Members Council's input this year, we are suggesting any or all of the options below could be followed:

1. **Vision and values:** We are planning on reviewing the Trust's vision and values. The Members Council could provide valuable input into this review, for instance through a one-off workshop or by setting up a short-lived working group;
2. **Feedback on Corporate objectives:** Building on last year's approach, asking the Members Council to provide feedback on the Trust's draft Corporate Objectives once these have been discussed by the Trust's senior managers. To deepen the engagement, the Members Council, particularly but not exclusively staff representatives, could also provide valuable advice on how the Trust Executive can make these objectives 'live' within the organisation;
3. **Allocating discretionary spend:** As a Foundation Trust it is important that we create a surplus to reinvest in maintaining and upgrading our services. However, if we deliver our financial plan for this year, we will generate a reasonable surplus and are likely to be in the position of having some discretionary one-off funding available. If the Members Council thought it appropriate, they could provide direction as to what initiative(s) this one-off funding could support. Through delivering the financial plan, this funding is likely to be up to £100,000 at year-end.
4. **Involving the wider Membership:** The Council may also want to provide a means of involving the wider Membership in annual planning. One option would be for a working group to develop survey questions about development priorities for the Trust which we could mail out to the Membership.

We would appreciate the Members Council's views on whether any of the options outlined above, or indeed other options, are suitable.

Amit Khutti
Director of Strategy and Service Performance
29th October 2007

Appendix 1

CORPORATE AIMS AND VALUES 2007/08

1. Patient Experience: To improve all aspects of the patients' experience, to continue to make the patient the centre of everything we do through a focus on consistently excellent customer care and consequently be the provider of choice.

2. Clinical Governance and Safety: To maintain quality and efficiency and continuously improve patient outcomes and assure patient safety.

3. Service Line Reporting: To develop an understanding of service line profitability to support strategic service planning, investment and performance improvement and promote good business practice..

4. Teaching: To provide excellent teaching, learning and development opportunities for all staff.

5. Specialist Services: To maintain and develop our specialist services.

6. Strategic Partnerships: To develop effective partnerships with all stakeholders, including the Members Council.

7. Our Workforce: To ensure we have a highly skilled, motivated, diverse, productive and customer focused workforce.

8. Modern Infrastructure: To ensure clinical care is supported and enabled by effective modern support services.

9. Innovation: To be innovative with our clinical services and business models, using the new Foundation Trust freedoms.

10. Integrated Governance: To further develop the Trust's framework for integrated governance.

Chelsea and Westminster Healthcare NHS
NHS Trust

Members' Council, 8th May 2008

AGENDA ITEM NO.	2.2/May/08
PAPER	Performance Report
LEAD EXECUTIVE	Lorraine Bewes – Director of Finance and Information
AUTHOR	Nick Cabon – Head of Performance & Information
SUMMARY	The purpose of this report is to provide information about the Trust's service performance for the period ending 31st March 2008. Based on performance to date we expect a rating of 'Excellent' for Quality of Services from the Healthcare Commission (HCC). An 'Excellent' rating is dependant, however, on three decisions by the HCC: • How they assess our performance on MRSA where we are above target for the year; • How they assess our data quality submission for the 18 weeks target; • How they assess our performance for patient experience resulting from the 2007 Inpatient Survey. We think it is unlikely that the HCC will assess these three targets in a way that prevents us from achieving an 'Excellent' rating, but we may not know for certain until the HCC publishes its results in the autumn.
BOARD ACTION	The Members' Council is asked to note and discuss the report.

Chelsea and Westminster Healthcare NHS

NHS Trust

PERFORMANCE REPORT FOR THE PERIOD MARCH 2008

1. PURPOSE

1.1. The purpose of this report is to provide information about the Trust's performance for April 2007 to March 2008. The Trust Board is asked to note the report and conclusions.

2. CONTENT OF PERFORMANCE REPORT

2.1. The report comprises of the following components:

- **External Dashboard – pg 5**
- **Internal Dashboard – pg 6**
- **Appendices**
  - **Activity Summary – pg 7**
  - **Efficiency and Resources Summary – pg 8**
  - **Access Summary – pg 8**
  - **Clinical Coding – pg 9**
  - **Infection Control – pg 10**
  - **Theatre Efficiency – pg 11**
  - **HR Summary – pg 12**

3. SUMMARY OF PERFORMANCE REPORT

3.1. The Trust is expecting to meet all of the Monitor targets other than MRSA where we have had 16 cases versus a target of 12 for the year, and Outpatient waiting times where we have had 13 breaches so far this year. We therefore expect a Monitor rating of 'Amber' for governance for Quarter 4, level 5 for Financial risk rating and Green for Mandatory Services.

3.2. For the Healthcare Commission (HCC) Annual Health Check we are on track to receive an 'Excellent' rating for quality of services. To achieve an 'Excellent' rating, we need to 'Fully Meet' Existing Targets (score 27+) and be 'Excellent' for New Targets (score 28+) as well as declare full compliance on core standards. We expect to score 28 points in each category, and so expect an overall rating of 'Excellent' for the year.

3.3. Although we are confident we will 'Fully Meet' the Existing Targets, there are still some uncertainties around the New Targets which could prevent us from receiving an 'Excellent' rating. To receive an 'Excellent' rating, we cannot 'Fail' any New target and cannot 'Underachieve' more than two targets.

3.3.1. <u>At risk of 'Failing'</u>: There is an outside chance we could 'Fail' the MRSA target for 2007/08 but this is highly unlikely given how the HCC assessed performance in 2006/07. We could also 'Fail' the data quality requirements for the 18 weeks target, but again believe this to be unlikely.

3.3.2. <u>At risk of 'Underachieving'</u>: We believe we are on course to 'Underachieve' the MRSA target. We may also 'Underachieve' the Waiting Times for Diagnostics target and the Patient Experience target, although in both cases we will not know the exact thresholds that the HCC will use until the autumn.

4. NEW AND EXISTING EXTERNALTARGETS

4.1. In February 2008 the Healthcare Commission published details of their scoring methodologies for New and Existing targets.

4.1.1. The 12 Existing targets will be assessed individually. Only 10 of the targets are applicable to this Trust. Therefore, the maximum score that we can receive for this component is 30 points (3 per target).

4.1.2. The 13 indicators for the New national targets have been combined into 10 targets.

The following indicators have been grouped into targets:

- MRSA bacteraemia has been combined with Clostriduim Difficile data quality to form one target.
- Data quality on ethnic group has been combined with Infant health inequalities.
- Waiting times for diagnostics has been combined with 18 Week Referral to treatment times milestones.

The remaining new indicators will be assessed individually. All 10 New targets are applicable to this Trust. Therefore, the maximum score that we can receive for this component is 30 points.

4.2. The Healthcare Commission (HCC) publishes definitive thresholds for Fully Meeting, Underachieving and Failing some indicators after the end of the financial year. This creates some ambiguity in our expected final position.

4.2.1.1. We are on track to receive a 'Fully Met' rating for the Existing national target group. If we 'Underachieve' on up to two targets and do not 'Fail' any then we receive a 'Fully Met' rating for this component. Our performance in the Outpatient waiting times indicator is slightly worse than the threshold, and we expect to 'Underachieve' this target. Furthermore, the achievement of the Convenience and choice indicator will depend on the time period over which they measure performance and on final performance thresholds, but we expect to 'Fully Meet' or 'Underachieve' this target. We expect to 'Fully Meet' all other Existing targets.

4.2.1.2. For the New national targets we can also afford to 'Underachieve' on up to two targets and not 'Fail' any and still receive an 'Excellent' rating.

4.2.1.3. We expect to 'Underachieve' the MRSA target and could still afford to 'Underachieve' on <u>either but not both</u> of the HCC 18 week target (a combination of the 18 week milestone target and the waiting times for diagnostic tests) and the Patient Experience target and receive an overall score of 'Excellent'.

- Over 93% of patients waiting for diagnostic tests waited less than 6 weeks in March. The construction that the Healthcare Commission has published regarding this indicator states that there is an "expectation that by 31st March 2008 patients should be seen within 6 weeks". Therefore it would be prudent to expect the target to be 100%. On this basis, we would 'Underachieve' the overall 18 week target.

- In terms of Patient Experience, the Healthcare Commission has not yet published the thresholds on which it will judge Trusts' performance. Last year we achieved this target; however, as there are a number of areas this year in which our performance is below the national average there is a risk that we will 'Underachieve' this target.

4.2.1.4. Although we do not expect to 'Fail' any New targets, any 'Fail' would mean that at best we could receive a 'Good' rating for Quality of Services.

- On MRSA, the HCC may judge that we have 'Failed' the target with 16 cases versus an official target of 12 but we think this is highly unlikely given their thresholds for 'Underachieving' and 'Failing' this target in 2006/07. In addition we will be arguing that our actual target should have been 15 cases in 2007/08, as discussed in previous reports. We have recently received confirmation that our MRSA bacteraemia target for 2008/09 will be no more than 19 cases, which strengthens our case for having the 2007/08 target changed to 15 cases.

- We have met the March milestones for the 18 weeks target in terms of performance, but we must also meet the data quality elements of this target. The Healthcare Commission has asked Trusts to comment on their proposed methodology for assessing data quality. This exercise was completed in April, and the Trust identified a number of factors for review. The most significant factor related to the proportion of elective patients who are admitted solely for diagnostic procedures. For our Trust, this has increased significantly in the past year as a result of data quality improvements in how we book patients – however, it is now important that the Healthcare Commission take account of this when constructing their indicator. We believe we will meet the data quality requirements and have put forward a strong case, but there is a chance that we could fail this requirement in which case we would not be able to achieve an 'Excellent' rating. We expect feedback on data quality in May, with an opportunity for Trusts to respond before final results are published on May 29th.

5. CORE STANDARDS

5.1. To score Excellent for Quality of Services as assessed by the Healthcare Commission, as well as meeting existing and new targets we must also declare full compliance with the Healthcare Commission Core Standards.

5.2. All of the assurance statements linked to the core standards have been reviewed by nominated lead Directors. A few areas have been identified that will require additional work including mandatory training and medicines management (storage). We are now focusing on these areas to assure ourselves of full compliance by the end of March.

6. ACTIVITY

6.1. March was not as busy as the same period last year: elective activity was 10% lower than the corresponding month last year; A&E attendances were down by 2% and non-elective activity was down by 5%. However, March 2007 was a

month of unusually high activity, and March 2008 had 2 bank holidays which accounts for the lower elective activity.

6.2. In terms of the full-year 2007/08, activity was higher than 2006/07 in all areas other than A&E attendances (-1.4% on last year):

- Outpatient attendances were 11.7% higher than 2006/07
- Elective activity (day case and inpatient) was 4.3% higher
- Non-elective acitivity was 1.8% higher

7. EFFICIENCY (AND OTHER TARGETS)

7.1. Clinical Coding – We continue to have a backlog of uncoded episodes but are planning to eliminate this backlog and come up-to-date with our coding in April and May 2008. We have recently approved a Recruitment & Retention premium to help staff the coding team with experienced clinical coders.

7.2. Efficiency and Use of Resources –

- The Trust's day case rate is slightly lower than in the corresponding period of last year.
- Elective and non-elective lengths of stay have both reduced and are below target and lower than in 2006/7.
- The outpatient new to follow-up rate has improved and is better than the target at an overall Trust level, although further work remains to be done in 2008/09 in some specialties to meet new to follow-up ratios agreed with in our new contract.
- Theatre utilisation has improved in terms of time and sessions used compared with last year. However, the average number of cases per list is slightly lower this year.

8. HUMAN RESOURCES PERFORMANCE

8.1. Staff in Post & Turnover

8.1.1. In March, the Trust showed an increase of 10.78wte staff inpost, which is an increase of 76.3wte on the same period last year.

8.1.2. Unplanned turnover (ie: resignations) decreased again in March, down to 0.63%. This represents the Trust's lowest turnover rate in the last 3 years. The two main reasons staff gave for leaving were 'Other/Not Known' and 'Promotion'.

8.2. Vacancies

8.2.1. The Trust vacancy rate decreased in March and is now at 13.0%, although this is still higher than the rate in March 2007 which was 11.7%.

8.2.2. As with the last few months, 'hot spot' staff groups for vacancies were Nursing and Midwifery Support (23.7%), Nursing and Midwifery qualified (14.6%) and Admin & Clerical (21.2%).

9. CONCLUSION

9.1. The Trust has performed well and, subject to thresholds and the methodology for reporting the 18 weeks indicator, is on track to receive an 'Excellent' rating.

9.2. Many of the indicators for 2007/8 will be rolled forward to next financial year. We need to ensure that we remain focussed on delivering the targets from the start of 2008/9.

Dashboard

Monitor Indicators

Indicator Name	Target	YTD Performance	Expected Performance at Year End	Score Year to Date	Score Expected at Year End	Weight of Indicator
Cancer patients waiting 31 days from decision to treat to first treatment	98%	99.2%		0.0	0.0	1.0
Cancer patients waiting 62 days from GP referral to first treatment	95%	100%		0.0	0.0	1.0
Elective booking	100%	100%		0.0	0.0	1.0
Outpatient booking	100%	100%		0.0	0.0	1.0
Elective patients waiting longer than the standard (6 month)	99.7%	100%		0.0	0.0	1.0
Outpatients waiting longer than the standard (13 weeks)	99.7%	99.6%		1.0	1.0	1.0
48 Hour access to GUM clinics - offered	100%	100%		0.0	0.0	1.0
MRSA cases	11	16		1.0	1.0	1.0
Cancer patients waiting 2 weeks for GP referral to first appointment	98%	99.8%		0.0	0.0	0.4
Cancelled operations rebooked within 28 days	100%	100%		0.0	0.0	0.4
Delayed transfers of care	96.5%	97.0%		0.0	0.0	0.4
Total time in A&E (4 hours of less)	98%	98.5%		0.0	0.0	0.4
Waiting times for rapid access chest pain clinic	99%	100%		0.0	0.0	0.4
				2.0	**2.0**	

Healthcare Commission Existing Targets

Indicator Name	Target	YTD Performance	Expected Performance at Year End	Score Year to Date	Score Expected at Year End
Cancer patients waiting 31 days from decision to treat to first treatment	98%	99.2%		3	3
Cancer patients waiting 62 days from GP referral to first treatment	95%	100%		3	3
Elective patients waiting longer than the standard (6 month)	0.03%	0.00%		3	3
Outpatients waiting longer than the standard (13 weeks)	0.03%	0.04%		2	2
Cancer patients waiting 2 weeks for GP referral to first appointment	98%	99.8%		3	3
Cancelled operations rebooked within 28 days	100%	100%		3	3
Delayed transfers of care	96.5%	97.0%		3	3
Total time in A&E (4 hours of less)	98%	98.5%		3	3
Waiting times for rapid access chest pain clinic	99%	100%		3	3
Convenience and Choice - Has the Trust got processes in place to ensure that nhs.uk is kept up-to-date? ***	Yes	Yes			
Convenience and Choice - Availability of slots	TBC	?		2	2
Patients waiting longer than 3 months for revascularisation	Not Applicable				
Thrombolysis - 60 minute call to needle time	Not Applicable				
			Available Points:	30	30
			Points Scored:	28	28
			Predicted Band:	Fully Met	Fully Met

Healthcare Commission New Targets

Indicator Name	Target	YTD Performance	Expected Performance at Year End	Score Year to Date	Score Expected at Year End
MRSA cases *	11	16			
Clostridium Difficile - data submitted within the deadline	Yes	Yes			
Clostridium Difficile - data submitted represents the number of infections	Yes	Yes		2	2
Clostridium Difficile - satisfactory number of NHS numbers	TBC	96%			
Clostridium Difficile - does the Trust have a target agreed with the appropriate commissioners? ***	Yes	Yes			
48 Hour access to GUM clinics - offered +	100%	98%		3	3
Drug misusers: information,screening and referral ***	Yes	Yes		3	3
Data quality on ethnic group	95%	95.5%			
Infant health and inequalities - smoking during pregnancy ***	13.9%	12.5%		3	3
Infant health and inequalities - breastfeeding initiation ***	82.4%	83.6%			
Experience of patients ++				3	3
Participation in Audits **	Yes	Yes		3	3
Self harm: compliance with NICE guidelines ***	Yes	Yes		3	3
Waiting times for diagnostics +	100%	93.6%			
Referral to Treatment times - admitted patients recorded on the national RTT collection +	90%	94%			
Referral to Treatment times - non-admitted patients recorded on the national RTT collection +	90%	96%		2	2
Referral to Treatment times - percentage of admitted patients who waited <18 weeks +	85%	91%			
Referral to Treatment times - percentage of non-admitted patients who waited <18 weeks +	90%	97%			
Emergency bed days	Reduction	-4.0%		3	3
Obesity: compliance with NICE guidelines ***	Yes	Yes		3	3
			Available Points:	30	30
			Points Scored:	28	28
			Predicted Band:	Excellent	Excellent

*-Trajectory as of February 2008; full year target is no more than 12 cases of MRSA

**- Participation in Audits- Data relates to April to Oct 07

*** These are the Healthcare Commission targets which will have a special data collection at year-end

+ These targets are based on performance in March 2008

++The Trust does not have any data relating to the Experience of patients indicator, but it expected that performance will be in line with previous years (ie Achieved)

Healthcare Commission Scoring System

	Targets	
Component of Healthcare Commission Assessment	Existing	New
Number of Applicable Indicators	10	10
Maximum number of points available	30	30
Range of points required to achieve a "Fully Met" or "Excellent" score for the component	27+	28+
Range of points required to achieve a "Almost Met" or "Good" score for the component	24 to 26	25 to 27
Range of points required to achieve a "Partly Met" or "Fair" score for the component	21 to 23	22 to 24
Range of points required to achieve a "Not Met" or "Weak" score for the component	<21	<22

Dashboard of Internal Indicators to Mar 2008

	Indicator Name	2007 / 2008 Year to Date	2007 / 2008 Target	Variance	Performance	Trend on last month
Internal Targets	Clinical risk management	Level 2	Level 2			⇔
	Hospital cleanliness	95%	60%	34.8%		⇔
	Better Hospital Food	95%	60%	35.0%		↑
	4 hour wait for emergency admission via A&E (trolley waits)	99.6%	99.0%	0.6%		⇔
	12 hour wait for emergency admission via A&E (trolley waits)	100%	100%	0.0%		⇔
	Clostridium Difficile Rate (in the over 65s, per 1000 bed days)	2.11	1.50	-41%		↓
	Patient Complaints *	95%	90%	4.5%		↑

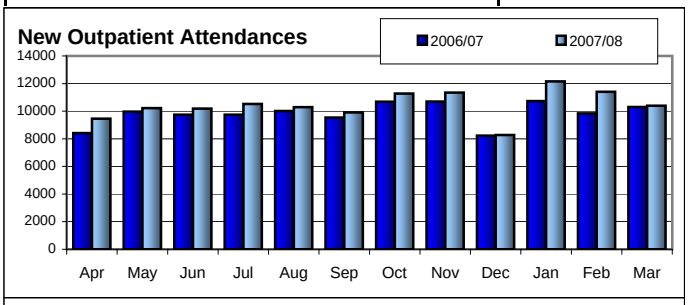
	Indicator Name	2007 / 2008 Year to Date	2007 / 2008 Target	Variance	Performance	Trend on last month
Efficiency & Resourc	Day Case Rate	72.0%	73.6%	-1.6%		⇔
	Total Inpatient Average Length of Stay	3.28	3.49	-0.21		↓
	Elective Inpatient Average Length of Stay	2.86	2.95	-0.09		↑
	Non-Elective Inpatient Average Length of Stay	3.38	3.61	-0.23		↑
	New to Follow Up Rate	1.87	1.96	-0.09		↑
	Outpatient Outcomes	88.4%	100.0%	-12%		↓

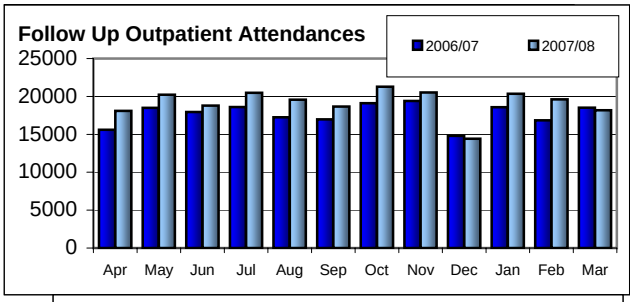
Key	
The Trust is on track to meet this target	
The Trust is slightly off track towards this target	
It does not seem likely that the Trust will meet this target.	
It is not possible to accurately assess performance in this area.	
Performance in this indicator is improving.	↑
There is no significant change in performance in this indicator.	⇔
Performance in this indicator is getting worse.	↓

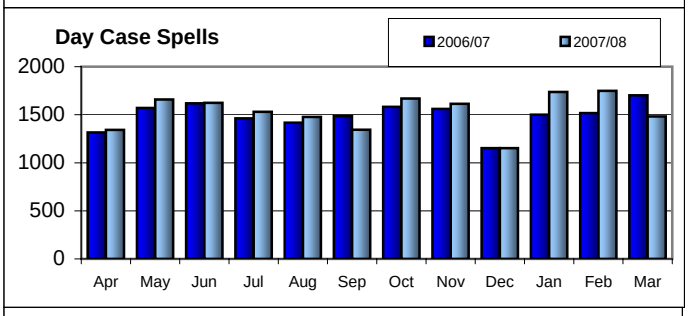
* Patient Complaints - Data relates to April 07 to February 2008

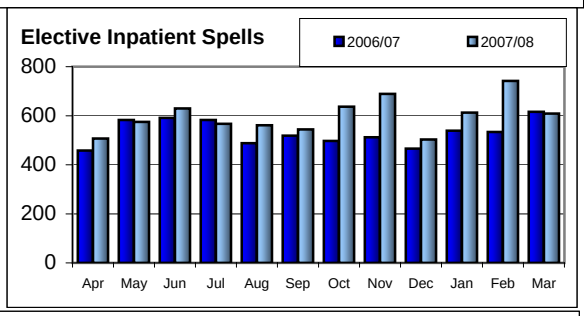
Activity Performance to Month 12

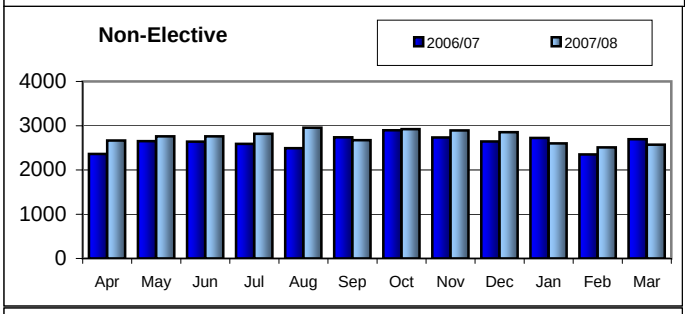
Points of Delivery	Actual Mar 2007	Actual Mar 2008	Actual to M12 2006/07	Actual to M12 2007/08	Variance on last year
New Outpatient Attendances	10350	10397	118031	128010	8.5%
Follow Up Outpatient Attendances	18431	18182	211227	239671	13.5%
Day Case Spells	1702	1482	17884	18244	2.0%
Elective Inpatient Spells	616	609	6386	7078	10.8%
Non-Elective	2696	2573	31515	32069	1.8%
A&E Attendances	8590	8399	98648	97246	-1.4%

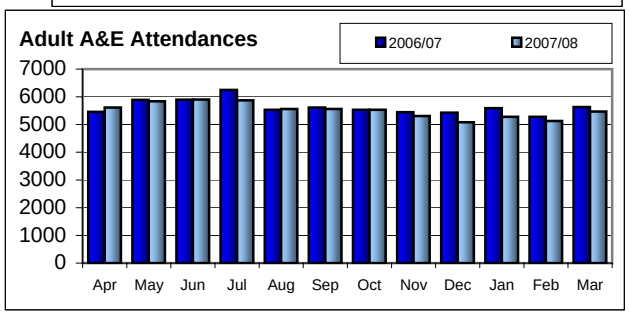


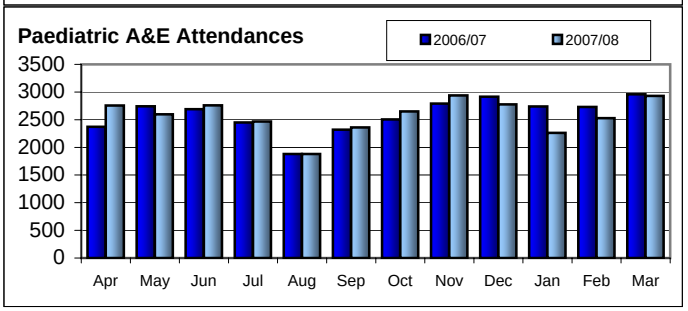






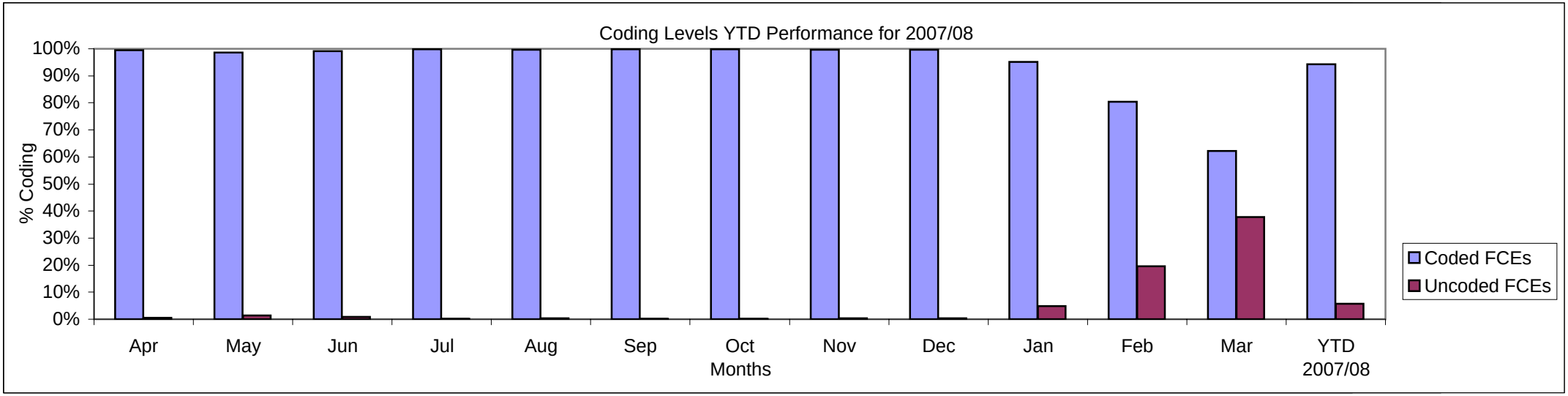




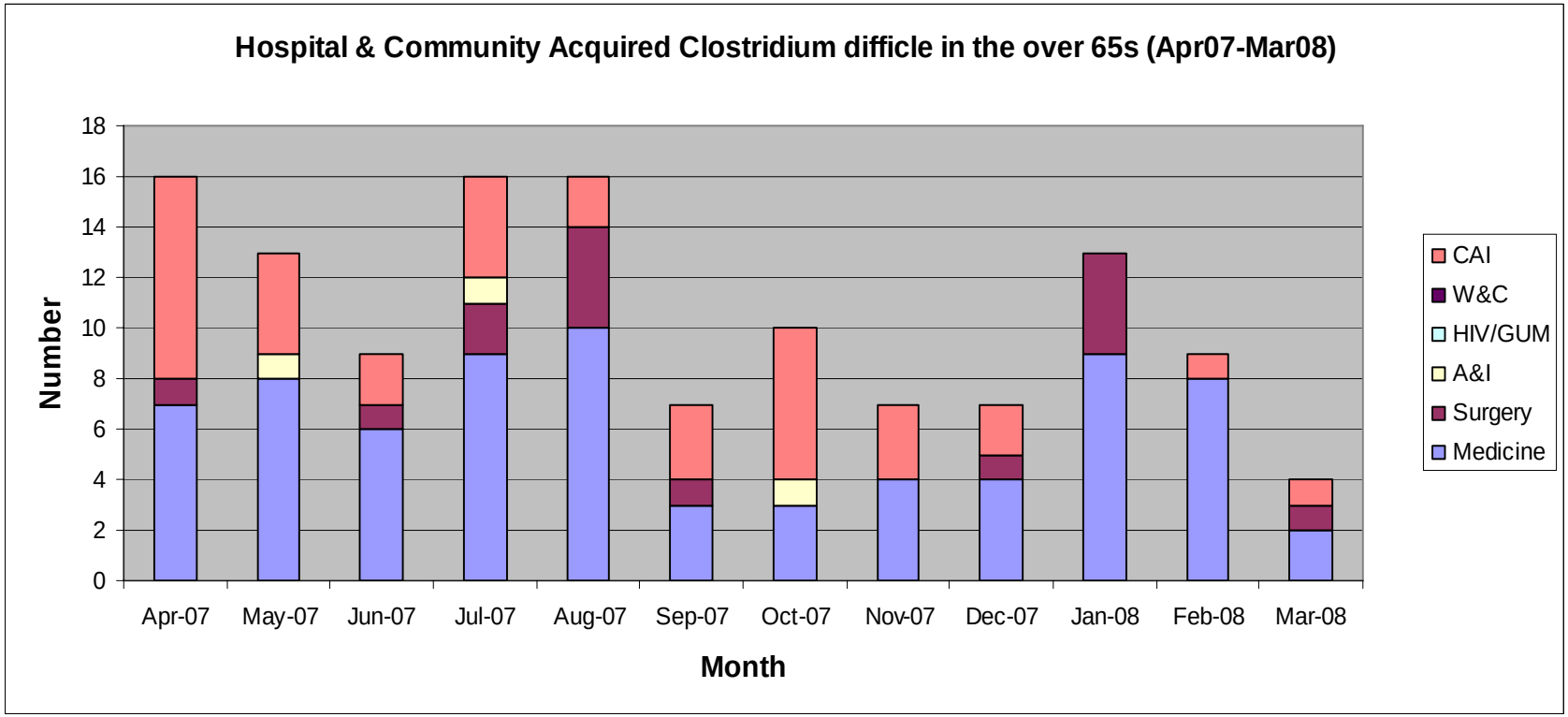


Trust Coding Levels for 2007/08

Coding Levels	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD 2007/08
Sum of U Code	29	83	56	7	17	13	16	17	24	300	1272	2345	**4179**
Sum of Valid HRG Code	5636	6236	6232	6094	6240	5751	6495	6464	5565	5958	5217	3859	**69747**
Total FFCEs	5665	6319	6288	6101	6257	5764	6511	6481	5589	6258	6489	6204	**73926**
Coded FCEs	99.49%	98.69%	99.11%	99.89%	99.73%	99.77%	99.75%	99.74%	99.57%	95.21%	80.40%	62.20%	**94.35%**
Uncoded FCEs	0.51%	1.31%	0.89%	0.11%	0.27%	0.23%	0.25%	0.26%	0.43%	4.79%	19.60%	37.80%	**5.65%**



Clostridium difficile 2007-2008



2005-2006 CDT over 65s – 59
2006-2007 CDT over 65s - 58
YTD 2007/08 CDT over 65s - 91

Our current average is 8 cases a month.

Reporting Month(March 2008) - 3 cases

Efficiency and Use of Resources to Month 12

Admissions

Indicator Name	2006/07	2006/07 to M12	2007/08 to M12	M12	Target
Day Case Rate	73.4%	73.7%	72.0%	70.9%	73.6%
Basket Procedures Day Case Rate	67.5%	66.7%	68.5%	54.4%	74.7%

LoS

Indicator Name	2006/07	2006/07 to M12	2007/08 to M12	M12	Target
Total Inpatient Average Length of Stay	3.57	3.57	3.28	3.28	3.49
Elective Inpatient Average Length of Stay	3.13	3.13	2.86	2.72	2.82
Non-Elective Inpatient Average Length of Stay	3.66	3.66	3.38	3.41	3.39

Outpatients

Indicator Name	2006/07	2006/07 to M12	2007/08 to M12	M12	Target
New to Follow Up Rate	1.78	1.79	1.87	1.75	1.96
Outpatient DNA Rate	11.9%	12.6%	12.6%	12.7%	TBC
Outpatient Outcomes	86.8%	79.8%	88.4%	91.8%	100.0%

Theatres

Indicator Name	2006/07	2007/08 to M11	M11
Theatre Session Utilisation	91.9%	96.8%	97.2%
Theatre Time Utilisation	82.4%	83.9%	85.9%
Theatre Cases per List	2.51	2.46	2.46

Access to Month 12

Access

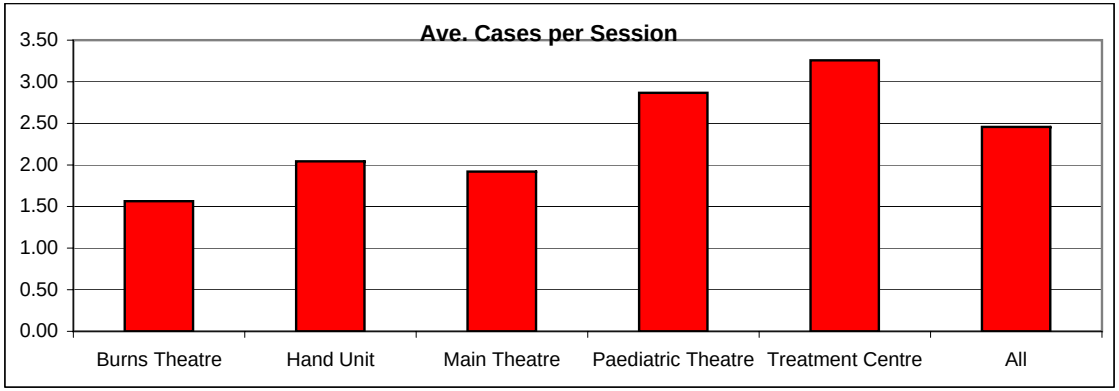
Indicator Name	M1 07/08	M2 07/08	M3 07/08	M4 07/08	M5 07/08	M6 07/08	M7 07/08	M8 07/08	M9 07/08	M10 07/08	M11 07/08	M12 07/08	Avg 2006/07	Avg 2007/08 YTD
Waiting List Suspensions (as % of waiting list)	12.68%	26.20%	23.10%	23.97%	21.64%	15.70%	21.60%	13.77%	14.08%	15.38%	16.38%	14.41%	13.03%	18.59%
Waiting List Suspensions > 3 months (as % of suspensions)	45.41%	45.30%	43.00%	45.60%	46.63%	40.90%	42.70%	46.40%	41.41%	31.97%	20.84%	22.55%	44.24%	40.92%

Theatre Resources Report

Theatre Utilisation

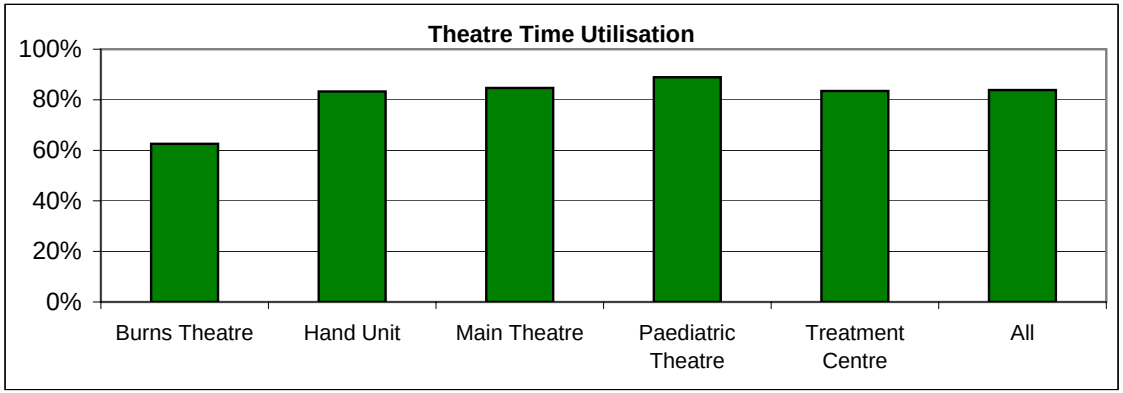
Avg. Cases per Session

Theatre	2006 / 07	2007 / 08 ytd	Last Month
Burns Theatre	1.80	1.56	1.79
Hand Unit	2.20	2.04	2.24
Main Theatre	1.92	1.92	1.93
Paediatric Theatre	3.07	2.87	2.50
Treatment Centre	3.18	3.26	3.36
All	**2.51**	**2.46**	**2.46**



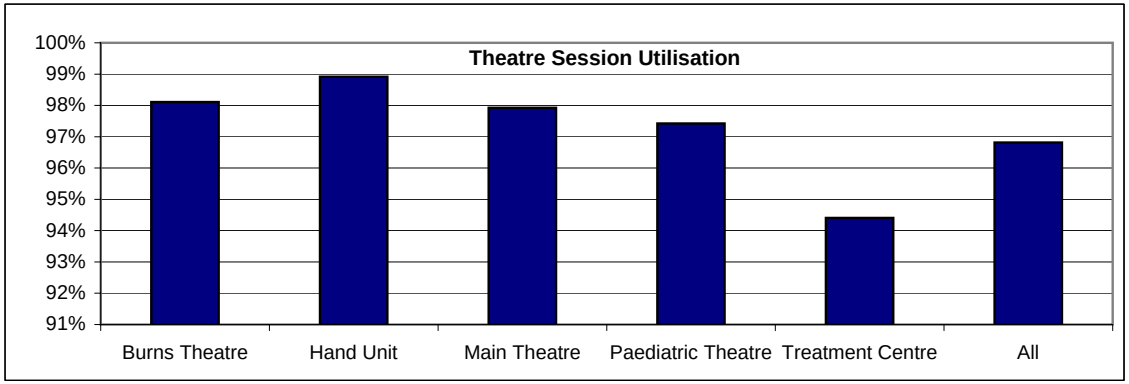
Utilisation of Time

Theatre	2006 / 07	2007 / 08 ytd	Last Month
Burns Theatre	70.8%	62.6%	65.2%
Hand Unit	77.4%	83.3%	86.8%
Main Theatre	85.0%	84.6%	87.3%
Paediatric Theatre	89.9%	88.9%	85.1%
Treatment Centre	78.4%	83.5%	86.1%
All	**82.4%**	**83.9%**	**85.9%**



Utilisation of Sessions

Theatre	2006 / 07	2007 / 08 ytd	Last Month
Burns Theatre	87.4%	98.1%	100.0%
Hand Unit	98.9%	98.9%	100.0%
Main Theatre	89.5%	97.9%	98.5%
Paediatric Theatre	94.3%	97.4%	100.0%
Treatment Centre	92.9%	94.4%	93.5%
All	**91.9%**	**96.8%**	**97.2%**

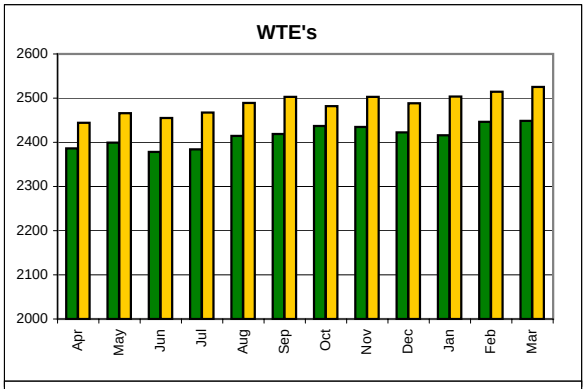


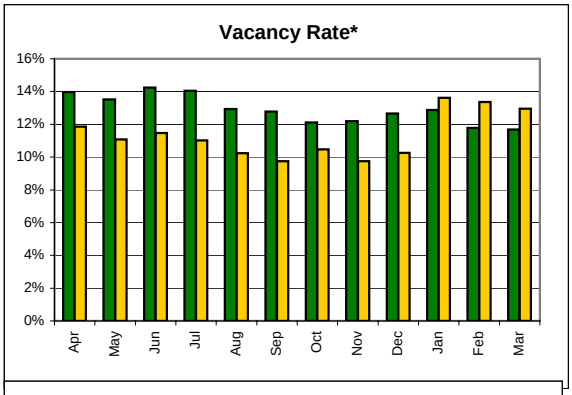
Data excludes emergency sessions, however emergency cases are included where they have been carried out on elective lists.

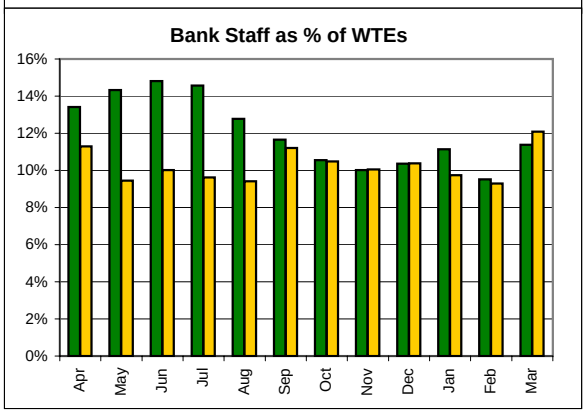
Data excludes emergency sessions, however emergency cases are included where they have been carried out on elective lists.

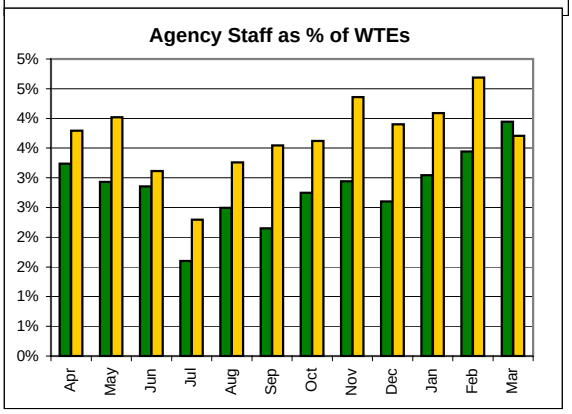
Workforce Performance to Month 12

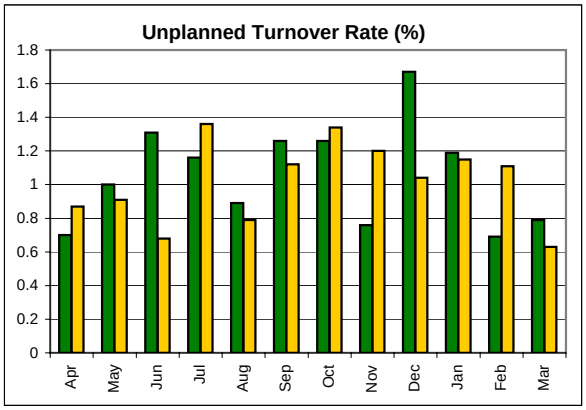
Indicator Name	Mar-07	Mar-08	Variance
Whole Time Equivalents (V	2449	2525	76
Bank Staff (WTEs)	279	305	26
Agency Staff (WTEs)	97	94	-3
Vacancy Rate	11.7%	13.0%	1.6%
Sickness (%)	3.7	4.0	-0.3

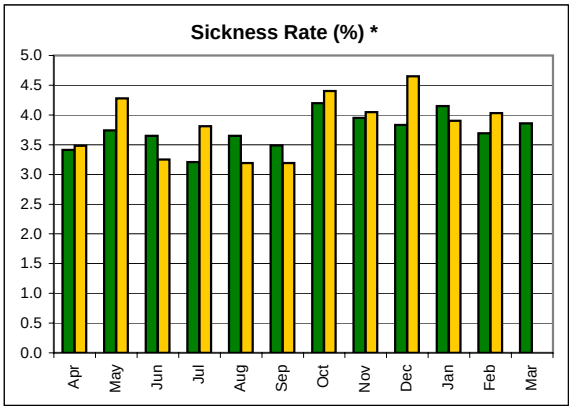


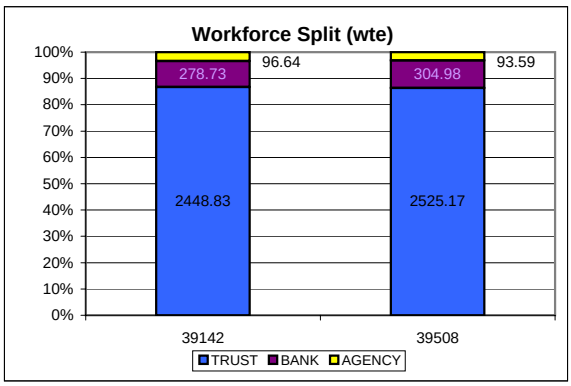












Key 2006/07 2007/08

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 8 May 2008

AGENDA ITEM NO.	2.3 /May/08
PAPER	Members' Council Report
AUTHOR	Julie Cooper, FT Secretary/Head of Corporate Governance
LEAD	Chris Edwards, Chairman
SUMMARY	This paper provides highlights from the Members' Council Sub Committee Meeting with regards to plans to both increase membership as well as engage with existing members. The paper also gives the membership figures as of 30 April 08 with commentary in regards to progress against membership targets as set out in the annual plan 07/08.
DECISION/ ACTION	The Council is asked to note the report.

MEMBERSHIP REPORT

1.0 Membership size and movements

OVERALL MEMBERSHIP OVERVIEW	Final Figures for 06/07	Final Figures for 07/08	Target for 07/08	Current figures as of 30 Apr 08	Target for 08/09
Members at start of year	10,740				13,140
New Members	5,162	557	2,809		
Members leaving	-2,615	-704	-1,958		
TOTAL	**13,287**	**13,140**	**14,138**	**12,899**	
PUBLIC MEMBERSHIP OVERVIEW	**Final Figures for 06/07**	**Final Figures for 07/08**	**Target for 07/08**	**Current figures as of 30 Apr 08**	**Target for 08/09**
Members at start of year	3,500	6982			6,580
New Members	4,192	76	837		
Members leaving	-710	-478	-698		
TOTAL	**6,982**	**6,580**	**7,121**	**6,467**	
PATIENT MEMBERSHIP	**Final Figures for 06/07**	**Final Figures for 07/08**	**Target for 07/08**	**Current figures as of 30 Apr 08**	**Target for 08/09**
Members at start of year	6,536	5898			6,095
New Members	969	362	1,769		
Members leaving	-1,607	-165	-1,179		
TOTAL	**5,898**	**6,095**	**6,488**	**5,964**	
STAFF MEMBERSHIP	**Final Figures for 06/07**	**Final Figures for 07/08**	**Target for 07/08**	**Current figures as of 30 Apr 08**	**Target for 08/09**
Members at start of year	704	*653			
New Members	1	127	203		
Members leaving	-298	315	-81		
TOTAL	***407**	**465**	**529**	**468**	

*The discrepancy between these two figures is due to on-going data migration during this period. The correct number of staff members as of 1 April 2007 is 653.

2.0 Membership Commentary

Recruitment and Engagement
The overall membership size has decreased since last year. The drop is mainly due to a decrease in public members, which is the hardest category in which to recruit. There is an increase in both the patient constituency and staff constituency.

The Members' Council voted to move to an 'opt-out' system for staff which will lead to a substantial increase in our overall membership. A letter from the Chairman to this effect has gone out with the April payslip and all staff will be put on the membership database on 2 June unless they decline. However, we must continue efforts to increase public and patient membership.

Initiatives to increase membership are outlined below.

Foundation Trust membership recruitment materials have now been developed using the new brand for use during both the week and going forward at all community and/or Trust events where there is an opportunity to promote membership. We will also be sending the leaflets to all local GP surgeries and libraries together with their own display stand with the view to increase public membership as well as the visibility of the Trust.

We are currently running a Membership Week leading up to the Open Day. We have 4 recruiters working in and outside the hospital to promote the open day as well as membership. We seem to be averaging 25 new recruits per member per day at the moment. We have set a very rough target of 500 new members by the close of the open Day. Following data cleansing, I think this figure will drop to closer to 400 due to people already being members or living outside the area.

On the actual Open Day, the Members' Council will have a high profile and representatives will be launching their 'Have Your Say' Sessions with the Members' Council which will then run throughout the rest of the year one hour prior to each Council meeting.

The Communications Sub Committee has also agreed to plans to designate an area within the hospital to serve, on a permanent basis, as the 'Membership Information Area'. In this space, we will mount a 60" Plasma Screen with a scrolling presentation about membership. The screen will also have an interactive component so that members can touch the screen to hear particular items. We will also use this area to display key information including *Trust News*, membership leaflets and profiles and photos of all Members' Council representatives. The Members' Council has also agreed to dedicate funds for the purchase of an electronic information board which would display 'what's on' in the Trust on a daily basis. This will be located in between the fish tank and the blue hospital information board. The information will be managed by ISS and the estates department.

These initiatives will serve to both increase membership size as well as engage with our existing members and we will track and report on progress regularly.

Diversity
We continue to work closely with Jane Collier, the Equality and Diversity Manager, to audit our current membership compared with the 'population' to identify groups which are under-represented. The committee will apply the equality and diversity assessment template to the Membership Development and Communications strategy and discuss whether it is fit for purpose at the July Sub Committee meeting in conjunction with the review of the strategy and our objectives for the year ahead. The latest ethnicity data as well as socio-economic profile of our membership can be seen in the draft annual plan.

Julie Cooper
May 2008

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting , 8 May 2008

AGENDA ITEM NO.	2.3 /May/08
PAPER	Members' Council Report
AUTHOR	Julie Cooper, FT Secretary/Head of Corporate Governance
LEAD	Chris Edwards, Chairman
SUMMARY	This paper provides highlights from the Members' Council Sub Committee Meeting with regards to plans to both increase membership as well as engage with existing members. The paper also gives the membership figures as of 31 March 08 with commentary in regards to progress against membership targets as set out in the annual plan 07/08.
DECISION/ ACTION	The Council is asked to note the report.

MEMBERSHIP REPORT

1.0 Membership size and movements

OVERALL MEMBERSHIP OVERVIEW	Final Figures for FY 06/07	Target from FY 07/08	Final Figures for FY 07/08	Target from FY 08/09	Final Figures for FY 08/09
Members at start of year	10,740			13,140	
New Members	5,162	2,809	557		
Members leaving or changing constituency	-2,615	-1,958	-04		
TOTAL	**13,287**	**14,138**	**13,140**		
PUBLIC MEMBERSHIP OVERVIEW	**Last Year**	**Next Year (Target) 07/08**		**Next Year (Target) 08/09**	
Members at start of year	3,500	6,982		6,580	
New Members	4,192	837	124		
Members leaving or changing constituency	-710	-698	-26		
TOTAL	**6,982**	**7,121**	**6,580**		
PATIENT MEMBERSHIP	**Last Year**	**Next Year (Target) 07/08**		**Next Year (Target) 08/09**	
Members at start of year	6,536	5,898		6,095	
New Members	969	1,769	305		
Members leaving or changing constituency	-1,607	-1,179	-108		
TOTAL	**5,898**	**6,488**	**6,095**		
STAFF MEMBERSHIP	**Last Year**	**Next Year (Target) 07/08**		**Next Year (Target) 08/09**	
Members at start of year	704	407		465	
New Members	1	203	128		
Members leaving or changing constituency	-298	-81	-70		
TOTAL	**407**	**529**	**465**		

2.0 Membership Commentary

Recruitment and Engagement
The overall membership size has decreased since last year. The drop is mainly due to a decrease in public members, which is the hardest category in which to recruit. There is an increase in both the patient constituency and staff constituency.

The Members' Council voted to move to an 'opt-out' system for staff which will lead to a substantial increase in our overall membership. A letter from the Chairman to this effect has gone out with the April payslip and all staff will be put on the membership database on 2 June unless they decline. However, we must continue efforts to increase public and patient membership.

Initiatives to increase membership are outlined below. There will be a Membership Week leading up to the Open Day. During the week, face to face recruiters will promote membership both within the hospital and externally in the local community. On the actual Open Day, the Members' Council will have a high profile and representatives will be launching their 'Have Your Say' Sessions with the Members' Council which will then run throughout the rest of the year one hour prior to each Council meeting.

Foundation Trust membership recruitment materials are now being developed using the new brand for use during both the week and going forward at all community and/or Trust events where there is an opportunity to promote membership. We will also be sending the leaflets to all local GP surgeries and libraries together with their own display stand with the view to increase public membership as well as the visibility of the Trust.

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We continue to work closely with Jane Collier, the Equality and Diversity Manager, to audit our current membership compared with the 'population' to identify groups which are under-represented. The committee will apply the equality and diversity assessment template to the Membership Development and Communications strategy and discuss whether it is fit for purpose at the July Sub Committee meeting in conjunction with the review of the strategy and our objectives for the year ahead. The latest ethnicity data as well as socio-economic profile of our membership can be seen in the draft annual plan.

Julie Cooper
May 2008

Members' Council Meeting , 8 May 2008

AGENDA ITEM NO.	2.6 /May/08
PAPER	Chair Appraisal
AUTHOR	Julie Cooper, FT Secretary/Head of Corporate Governance
LEAD	Chris Edwards, Chairman
SUMMARY	This paper provides a proposed process by which to appraise the performance of the Trust chairman which would be carried out on an annual basis.
DECISION/ ACTION	The Board is asked to discuss and agree to the process.

Chairman Appraisal process

1.0 Introduction

The following paper outlines the process for appraisal of the Trust Chairman on an annual basis. The paper highlights the key role that the Chairman of the Trust plays as set out in the job description used to recruit the current Chairman and suggests a process by which to conduct the appraisal.

2.0 The Constitution and Monitor Code of Governance (The code)

The Monitor Code of Governance stipulates that the board of directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.

The Code Provision D.2 Stipulates the following with regards the evaluation of the Chairman:

The board of directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.
The board should state in the annual report how performance evaluation of the board, its committees and its individual directors including the chairman, has been conducted, bearing in mind the desirability for independent assessment, and the reason why the NHS foundation trust adopted a particular method of performance evaluation.

The board of governors which is responsible for the appointment and re-appointment of non-executive directors, should take the lead on agreeing a process for the evaluation of the chair and the non-executives, with the chairman and the non-executives. The outcomes of the evaluation of the chairman and the non-executive directors should be agreed by governors. The governors should bear in mind the desirability of using the senior independent director to lead the non-executive directors in the evaluation of the chairman. The board of governors should assess its own collective performance and its impact in the NHS foundation trust.

Supporting principles
■ Individual evaluation of directors should aim to show whether each director continues to contribute effectively and to demonstrate commitment to the role (including commitment of time for board and committee meetings and any other duties). The chairman should act on the results of the performance evaluation by recognising the strengths and addressing the weaknesses of the board, identifying individual and collective development needs and, where appropriate, proposing new members be appointed to the board or seeking the resignation of directors.

3.0 The Role of the Chairman

The post has two different roles: chairmanship of the foundation trust and chairmanship of the Members' Council. It is a statutory requirement that both roles are filled by the same person.

Chairmanship of the Foundation Trust

The main formal responsibility in this role is to provide leadership to the board of directors, ensuring its effectiveness in all aspects of its role and setting its agenda.

The board is collectively responsible for exercising the powers and performance of the trust. The chairman is specifically responsible for:

- Ensuring that the Board of Directors and the Members' Council work together effectively.

- Ensuring that the directors receive accurate, timely and clear information appropriate for their duties.

- Ensuring the effective communication with stakeholders.

- Facilitating the effective contribution of executive and non-executive directors and constructive relationships between them.

- Reviewing the performance of the non-executive directors and the Chief Executive and advising on their development.

Beyond these formal responsibilities the chairman also needs to:

- Act as an ambassador for the Trust within the wider NHS, with relevant local authorities and partner institutions and to develop constructive relationships with each of these.

- Act as a sounding board and counsel for the Chief Executive.

- Encourage capitalising on the freedoms of being a Foundation Trust and the adoption of best commercial management disciplines.

- Be recognised, alongside the Chief Executive, as a leader within the Trust and the wider health community.

Chairmanship of the Members' Council
The Members' Council works with the Board of Directors as a 'critical friend', helping to shape the way the trust develops its services and holds the Board of Directors to account for the performance of the Trust.

Specifically, the chairman's role is to:

- Ensure the effective joint working of the Members' Council and the Board of Directors.

- Ensure that the Members' Council receives accurate, timely and clear information to allow it to fulfil its role.

- Help members of the Council individually and collectively to develop their understanding of the trust and of the role they are required to fulfil.

4.0 The Appraisal Process

As the chairman has responsibility for chairing both the Board of Directors, and the Members' Council each body is required to provide feedback to the chairman on the performance of his duties – particularly in relation to how it might be improved. The document below is intended to guide directors through the intended role of the chairman so that they may comment on his effectiveness in relation to this role.

In completing the boxes, Directors should highlight any particular strengths or areas for improvement. Completed forms would be sealed in self-addressed envelops to the deputy chairman.

All Directors:

Key competencies and behaviours	High Performance Indicators	Comments
"Committed to maximising long-term value"	▪ Prepared to challenge established thinking on current strategy or practice for the longer-term benefit of the Trust. ▪ Draws on real-life examples from experience in a way that illustrates possible directions. ▪ Is focused on ensuring that the Trust performs to the highest levels of stakeholder expectation.	
"Helps shape corporate strategy"	▪ Is well informed about the Trust and the external environment, bringing that knowledge to bear in the development of Trust strategy. ▪ Raises relevant strategic issues (such as competition and marketplace issues), influencing the shaping of Trust or Directorate/Departmental strategy. ▪ Effectively contributes to the evolution of the corporate strategy and assists in its implementation through advice and counsel. ▪ Uses relevant experience to add value to all strategic discussions.	
"Demonstrates independence of judgement"	▪ Willing to stand up for and defend own beliefs and values in the face of opposition. ▪ Able to challenge effectively outside own area of expertise. ▪ Demonstrates the courage to take a stand and challenge others' assumptions, beliefs or viewpoints as necessary for the good of the organisation.	

Key competencies and behaviours	High Performance Indicators	Comments
"Questions intelligently, debates constructively, challenges rigorously and decides dispassionately"	▪ Asks searching questions which are focused on the key value at risk issues for the Trust. ▪ Willing to challenge openly and rigorously, without leading to unnecessary conflict. ▪ Takes difficult decisions dispassionately whilst also being aware of the political implications. ▪ Able to deal effectively with complexity and assimilates knowledge quickly.	
"Has the trust and respect of other members of the Board"	▪ Immediately commands the respect of his/her Board colleagues. ▪ Comments and observations are valued by all Directors. ▪ Is seen as even-handed in all his/her dealings with the Board. ▪ (NED) Supports executive colleagues in their leadership of the Trust whilst monitoring their conduct and performance.	
"Effective member of the Board team"	▪ Demonstrates openness to being challenged on assumptions, beliefs, viewpoints and is willing to re-examine them in order to reach new conclusions. ▪ Will participate in robust and rigorous debates and then work with peers to arrive at new solutions. ▪ Listens sensitively to the views of others, inside and outside the Board.	
"Uses network of contacts effectively"	▪ Is always alert to how network of contacts may be utilised for the benefit of the Trust.	

The Chairman

In addition, the Chairman must demonstrate the following:

Key competencies and behaviours	High Performance Indicators	Comments
Provision of effective leadership to the Board	▪ In conjunction with the Nomination Committee, and the Search and Appointments Committee ensures high quality Board composition with an appropriate balance of skills and experience. ▪ Pro-actively manages annual calendar of business to ensure most appropriate use of Board's time. ▪ Engages and supports individual members to enhance Board activities and discussions. ▪ Ensures that the Boards operate effectively as teams. ▪ Ensures that membership of the Boards is a stimulating and enjoyable experience for Board members and Council Members.	
Effective Chairmanship of meetings	▪ Empowers members of both Boards to challenge issues openly while preventing unnecessary or acrimonious conflict. ▪ Encourages and manages vigorous debate whilst achieving closure on issues. ▪ Ensures time is allocated appropriately, ensuring business of meeting is completed whilst allowing appropriate discussion of individual items.	
Be a respected Ambassador for the Trust	▪ Be comfortable dealing with political and regulatory interests. ▪ Able to command respect of key opinion formers. ▪ Has the skills to Chair an Annual General Meeting and deal with challenging and diverse stakeholder questions.	

Any general comments which may help improve the performance of the chairman:
Rater name_____ **Date**__

5.0 Board Action

The board is asked to approve the process and questionnaire for appraisal of the Chairman

Members' Council Meeting , 8 May 2008

AGENDA ITEM NO.	2.7 /May/08
PAPER	Members' Council Funding Criteria
AUTHOR	Julie Cooper, FT Secretary/Head of Corporate Governance
LEAD	Chris Edwards, Chairman
SUMMARY	This paper provides some criteria for the use of Members' Council funding as well as a process by which the funds are allocated and accounted for.
DECISION/ ACTION	The Council is asked to note the administration arrangements for the Members' Council funding.

Members' Council Funding
A process for the allocation of funds

1.0 Background

The decision was made at the November 2007 Members' Council meeting that a recurring budget of £100,000 per financial year was to be made available to the Members' Council to spend at their discretion on relevant projects.

An initial allocation of £35,000 has been agreed to go towards the hospital Open Day, a dedicated membership week leading up to the open day, the creation of a membership information area in the hospital, and the improvement of patient and public information.

It is important that we have some explicit criteria for the use of these funds. This paper proposes some possible criteria as well as a process by which the funds could be allocated and accounted for.

2.0 The Criteria for Use of Funding

Members' Council funding should be aimed at projects that benefit our membership or specifically patients and the care we provide them. A short business case should be made to this effect including both estimated expenditure and deliverables.

The Trust Board, The Members Council and/or one of its Sub Committees can raise a proposal for funding. 75% of Council Members must agree to the proposal. A vote can be taken by those present at a Council Meeting or by post and/or email with a clear deadline for a response. Proposals for funding will become a standing agenda item for each Council meeting.

An initial suggestion is that 40% of the £100,000 annual budget should be for the discretion of the Membership Development and Communications Sub Committee to spend on membership related activity such as the Membership Week and the engagement of members.

3.0 Accounting

The £100, 000 will become a part of the Foundation Trust budget and managed by the Foundation Trust Secretary under the direction of the Director of Governance and Corporate Affairs. The budget is annual and recurring until further notice. All the initial estimates for funding will subsequently be confirmed with final invoices and filed accordingly for public scrutiny. Any residual funds from one financial year cannot be carried over.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 8 May 2008

AGENDA ITEM NO.	2.7 /May/08
PAPER	Proposed Questionnaire for Members' Council Self-Evaluation
AUTHOR	Julie Cooper, FT Secretary/Head of Corporate Governance
LEAD	Chris Edwards, Chairman
SUMMARY	This paper provides a draft questionnaire to be used for a self-evaluation of the Members' Council performance. The evaluation would be carried out on an annual basis and an analysis of the results would be led by the Chairman. The aim of the questionnaire is to evaluate and improve the performance of the Members' Council.
DECISION/ ACTION	The Council is asked to agree the questionnaire and process.

1.0 Background

The Monitor Code of Governance states in provision D.2.2 that …*Led by the chairman, the Members' Council should periodically assess their collective performance and they should regularly communicate to members details on how they have discharged their responsibilities, including their impact and effectiveness on:*

■ *advising the board on the forward plans of the NHS foundation trust; and*

■ *communicating with their member constituencies and transmitting their views to the board of directors.*

The Members' Council should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.

2.0 The Role of the Members' Council

In order to devise an effective process for evaluation of the Members' Council, it is important to have a clear description of the role the Council is to play in relation to the Trust. An overview of the role of the Council, as it is communicated to all new Council Members upon their induction, is attached at Annex I.

3.0 The Process

This paper provides a draft questionnaire to be used for a self-evaluation of the Members' Council performance. The evaluation is to be carried out on an annual basis and an analysis of the results should be led by the Chairman.

Options on how we administer the evaluation are: 1/Council Members would be asked to complete the form individually. They could do so anonymously or include their name on the form. A report of the results would then be brought back to the Council highlighting areas of poor performance and areas where there were discrepancies for consideration and action. Option 2/ the evaluation would be completed jointly at a Members' Council meeting with a collective discussion around each question regarding performance.

4.0 The Questionnaire

The draft self-evaluation questionnaire is attached at appendix 2. It is a combination of the recent Monitor Governor's questionnaire as well as those used by Chesterfield and South Staffordshire NHS Foundation Trusts.

5.0 Action from Members' Council

The Members' Council is asked to agree the questions, identify any further questions and agree the preferred process and timescale.

ANNEX I: THE ROLE OF THE MEMBERS' COUNCIL

The Members' Council is made up of patients, public, staff and our partners in the NHS, local authorities and universities. A driving force behind NHS Foundation Trusts is the active participation of local people, patients and staff. A crucial role of the Members' Council will be to engage with the hospital membership as well as with the broader communities which the hospital serves.

Some of the key roles of a Council Member will be to:

- provide views to the Board of Directors on future plans for the hospital and services
- respond to the Board of Directors on specific issues
- decide the remuneration, allowances and other terms and conditions of office of the Non Executive Directors
- serve the interests of the community they represent
- appoint the Chairperson, other Non Executive Directors and Financial Auditor
- approve the appointment (by the Non Executive Directors) of any new Chief Executive
- review the Trust's constitution
- implement and review the Trust's Membership Development and Communication Strategy.

Roles and responsibilities of the Members' Council in relation to the Trust Board of Directors

The Members' Council is responsible for representing the interests of the local community in the management and stewardship of the Trust, and for sharing information about key decisions with other NHS Foundation Trust members. The Members' Council is not responsible for the day to day management of the organisation – e.g. setting budgets, staff pay and other operational matters – which remain a matter for the Board of Directors.

The Members will enable local residents, staff and key stakeholders to influence decisions about spending and the development of services and the Members' Council will also appoint the chair and non-executive directors of the Board of Directors.

Governance arrangements for each Foundation Trust will ultimately be tailored to the individual circumstances of each Trust, reflecting the range of diverse relationships with patients, the local community and other stakeholders.

Council Members should get involved in Influencing policy and strategy – for example, in developing the annual forward plan for Monitor and in Membership recruitment and development

The role of the Members' Council in seeking the views of patients and the public

Council Members can bring a community perspective to solving issues and inform service changes by engaging with the broader membership, which will encompass the views of patients, staff and members of the public.

There are many ways in which the Members' Council can work with the membership – for example, Councillor-led 'Have your Say' sessions for members and member focus groups on local priorities; and open days and seminars (like the Hand Hygiene Awareness Week).

The Members' Council has several sub-committees, which Council Members are invited to join. These committees meet outside of the quarterly Members' Council meetings, and would require more time.

ANNEX II DRAFT QUESTIONNAIRE

Members Council Meeting, 8 May 2008

AGENDA ITEM NO.	3.1/May/08
PAPER	Finance Report – 12 months to March 2008
AUTHOR	Lorraine Bewes, Executive Director of Finance
LEAD	Lorraine Bewes, Executive Director of Finance
EXECUTIVE SUMMARY	This paper is the final report on the Trust's financial performance for the year ended 31st March 2008. The Trust has completed the financial year with a revenue surplus of £14.6m. This is an excellent achievement compared with the planned surplus of £5.5m and is attributable to both increased activity and cost control. The year-end position also means that the Trust has achieved a financial risk rating of "5" at month 12, in line with the forecast expectation. Cash balances at the end of March 2008 were £35.9m which is ahead of the Monitor plan of £18.4m. This surplus against plan is driven by the cumulative I&E surplus together with slippage on capital spend and an improvement in working capital.
DECISION/ ACTION	The Members' Council is asked to note the year end financial position.

Financial Summary to March 2008

1. Introduction

1.1. This paper presents the financial position for the twelve months to the end of March 2008. The key points set out in the table below are that the Trust has achieved a surplus of £14.6m as at Month 12, which represents an over achievement of £2.5m compared to the forecast surplus of £12.1m.

	Year to 31st March 2008			
	Budget £'m	Actual £'m	Variance £'m	% Var
Income	257.1	258.2	1.1	0.4%
Expenditure	234.7	227.8	6.9	2.9%
EBITDA	22.4	30.4	8.0	
EDITDA Margin %	8.7%	11.8%		
Interest, Dividends and Depreciation	16.8	15.8	1.1	
Surplus/Deficit (-ve)	5.5	14.6	9.1	
Surplus Margin %	2.2%	5.7%		
ROA %				
Liquidity (days)	37.6	54.9		
Risk Rating		5		

2. Summary Financial Position at Month 12

2.1. The income and expenditure position to the end of March represents a £9.1m favourable variance against plan, with an in-month favourable variance of £1.6m.

2.2. The key factors behind the improvement in the position compared to the forecast outturn position are as follows:

- The release of £1m of balance sheet provisions in respect of Agenda for Change costs. These provisions were set up at the end of 2006-07 to provide for the expected cost of staff moving to AfC terms and conditions during the financial year 2007-2008, however a review of the provision as at 31st March 2008 has shown that £1m is no longer required.

- The release of £1.2m of balance sheet provisions for bad debts following a detailed review of the Trust's current aged debt position. This reflects improved cash collection on debtors during the year.

- The forecast position had included a prudent provision of £0.5m against the non-achievement of the 18 week activity targets. However at Month 12 an assessment of the Trust's overall activity performance has confirmed that the 18 week target has been achieved, therefore the year-end position is £0.5m better than the

forecast. This £0.5m improvement is however mitigated by an adjustment of £1m against contract income in Month 12 in relation to provisions for credit notes for certain PCTs where queries have been raised relating to 2007-2008 activity billing.

- There has been additional non-recurrent slippage of approx £1.5m against development funding held in Reserves. In previous months a prudent assumption had been made that this funding would be spent, however delays in starting certain key projects have meant that expenditure has not been incurred in 2007-2008.

- These positive movements compared to the forecast position are off set against a deterioration in the front line Directorate final positions of approximately £0.5m compared to the Month 11 forecast.

2.3. The EBITDA margin remains ahead of plan at 11.8% for the financial year 2007-2008, compared to a planned EBITDA margin of 8.7%. The Trust's financial risk rating at month 12 is a "5" in line with expectations.

2.4. The key issues driving the in month favourable variance of £1.6m at Month 12 are as follows:

2.4.1. Contract income under performed against budget in month by £1.6m. The main reason for this deterioration is that prudent provision has been made to cover disputed PCT activity at the year-end. In addition to this, activity in Month 12 was slightly lower than expected due to the Easter bank holiday falling in March. This would have reduced elective capacity by approximately 10%.

2.4.2. The pay position improved by £1.2m in Month 12 due to the release of £1m in respect of Agenda for Change provision previously held on the balance sheet.

2.4.3. Similarly, the key reason for the non pay improvement of £1.1m in month is the fact that £1.2m of bad debt provision was released in the final month of the year.

3. Directorate Positions

3.1. Although the final Trust position at Month 12 is an improvement compared to the forecast, within this position the front line Directorates closed the year with a total over spend position of £0.7m compared to a forecast of £0.2m. The key reasons for this deterioration are as follows:

3.1.1. Within the A&I Directorate the position deteriorated in Month 12 due to further pressure on pay and non-pay budgets relating to late charges from CNWL Mental Health Trust for maternity cover in respect of a Clinical Psychologist in the Chronic Pain service and the continuing pressure on MSSE budgets.

3.1.2. The Surgery Directorate closed the year with a position £0.2m worse than the forecast due to high expenditure on prosthetics in Month 12 and an adverse impact on plastics relating to the year-end stock count.

3.1.3. The HIV Directorate position was £0.1m worse than anticipated due to unforeseen expenditure in Month 12 on small items of furniture and office equipment.

4. Savings

4.1. The position against the full year savings target for 2007-2008 of £8.45m is an over achievement of 4%, in line with the position anticipated at M11.

5. Underlying Surplus

5.1. The Month 12 surplus position of £14.6m includes a number of non-recurrent benefits, as outlined in the table below:

2008/09 - Underlying Surplus

	£000s	£000s
Actual Outturn Surplus 07/08		14,625
Non Recurrent Adjustments in 2007/08		
Non recurrent expenditure in 2007/08	2,491	
Non recurrent savings and benefits	-9,312	-6,821
Full year effect of 2007/08 measures		
Developments approved in 200708	-825	
Full year effect of 2007/08 cost pressures already approved	0	-825
Underlying Outturn Surplus 07/08		6,979

Balance Sheet

6. Debtors & Provisions (Form F7 & F11)

6.1. Overall aged debtors have increased by 28% over the previous month due to the need to get any outstanding billing raised before year-end close. The increase in St Stephens Aids trust balance is due to combining the separate accounts for fixed costs and variables.

6.2. There has been a further decrease in the level of overseas patients age debt by 16% whereas the private patients age debtors have increased by 4%.

6.3. The provision for bad debts is £2.5m against the outstanding aged debtors of £5.9m. This represents provision coverage for 42% of total aged debtors.

7. Creditors (Form F8)

7.1. The aged creditors are £5.4m at the end of March 2008 and represent a decrease of 22% from February 2008. This decrease is partly due to large value invoices from British Telecom being paid for the Picture Archiving & Communications System (PACS).

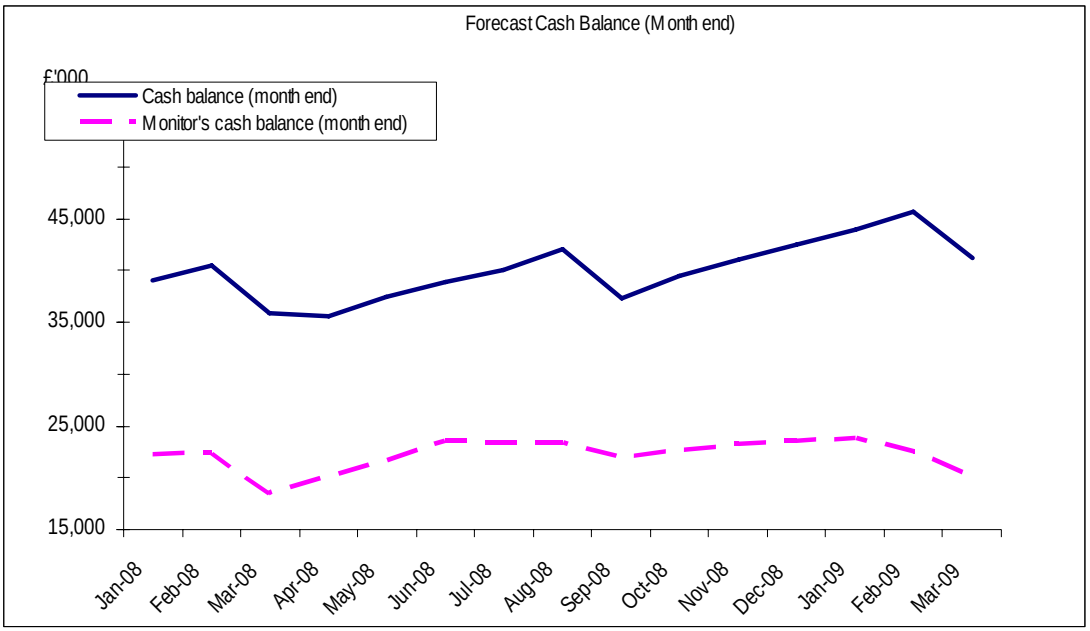
7.2. A cumulative BPPC target of 95% was achieved by the Trust in this month. A target of 91% for the value of invoices paid within 30 days was also achieved for March 2008.

8. Cash Position (F9)

8.1. The cash position at the end of March 2008 with a balance of £35.9m is below the internal forecast of £42.5m and is ahead of the Monitor plan of £18.4m. The negative variance of £6.6m against the cash forecast is due to the fact that the Trust anticipated an advance payment of April 2008 service level contract, promised by some of the local Commissioners, which did not fully

occur. The Trust has received an advance payment of £2.1m from the promised amount of £8.7m by NHS Bodies.

8.2. The cash forecast indicates that the Trust will be on average, for the next 12 months, at least £15m ahead of the plan submitted to Monitor in May 2007 as a part of our three year annual plan process.



9. Treasury

9.1. The prospect for the US economy has deteriorated over the last month and the financial markets have taken a further turn for the worse. This has increased the downside risk to UK growth in the short term. The Bank of England's Monetary Policy Committee has decided to maintain the interest rate at 5.25% in March 08. The average over night and 3 month LIBOR in the month of March 08 was 5.38% and 5.89% respectively.

9.2. The Trust has a committed facility of £18m set up with RBS. This facility has not been utilised year to date and there are no plans to utilise it next year.

9.3. The returns on the Trust's short term deposit investments have historically outperformed the cost of financing the Trust loans and in this month the Trust managed to achieve interest rate gain of 24 basis points. The return achieved in this month on short term deposit investments is below the over night and 3 months LIBOR by 10 and 61 basis points only.

	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08
	%	%	%	%	%	%
Weighted average investment returns	5.84	5.94	5.67	5.45	5.28	5.28
Weighted average cost of Loans	(5.07)	(5.07)	(5.04)	(5.04)	(5.04)	(5.04)
Average interest rate gains	0.77	0.87	0.63	0.41	0.24	0.24

Capital Programme

9.4. The actual capital expenditure for the financial year 2007-2008 was £9.6m, which is 45% of the capital budget for the year (£21.5m). This is an overall under spend against budget of £11.9m which includes commitment of £4.6m, slippage of £5.8m and unused contingency of £0.8m.

9.5. The total committed of £4.6m relates to some high value orders which were placed late in the financial year 07-08 but did not materialise before end of 31st March 2008. It includes Radiology equipment (CT & MRI scanners of £1.7m), and other miscellaneous equipment (£0.4m), buildings (£2.4m) and IT (£0.1m).

9.6. Building projects scheduled to slip into the next financial year 2008-09 include Private Maternity (£1.9m - planned to go live in June 08), Regional Burns Unit (£0.3m) which has been delayed pending agreement of the tariff for burns services and Additional Administrative Accommodation (£1.1m), to enable moves associated with the strategic 10 year plan for the hospital.

Glossary of Terms

ACU: Assisted Contraception Unit

AFC: Agenda for Change

Basket procedures: List of procedures deemed by Audit Commission to be day cases

BPPC: Better payment practice code (code for paying suppliers on time)

CHKS Benchmark: External benchmark club

DNA: Do not attend

Downside risk: Things could get worse

EBITDA: Earnings before interest tax depreciation amortisation

ETWD: EU Working Time Directive

Failed day case: planned day surgery where patient is admitted

FT: Foundation Trust

HHNT: Hammersmith Hospitals NHS Trust

I & E: Income and Expenditure

Internal indicators: indicators determined by Board which are over and above the Healthcare Commission and Monitor targets

LAS: London Ambulance Service

MFF: Market forces factor

MPET: Multi-professional education and Training

NICU: Neonatal Intensive Care Unit

PACS: Picture Archiving Communication System e.g. Digital x-ray

PDC Drawdown: Public dividend capital (equity finance vs. loan finance)

SaFF Income: Income under contract from PCT

SLA: Service Level Agreements

PTA: Professional and Technical ..

Ring fenced: Predetermined use for funds

Trolley procedures: List of procedures deemed by Audit Commission to be in-hospital cases

Workforce indicators: Internal indicators regarding staffing

W & C: Women and Children's

Upside Risk: Things could get better